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There's A ***New*** Opportunity
You Can't Afford to Ignore...

Medication Therapy Management

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Special Continuing Education Supplement

In order to better serve our members, NCAP will mail a special CE supplement only to members who request it. If you would like to be added to the CE mailing list please contact Teressa Reavis at teressa@ncpharmacists.org or call 919.967.2237 ext. 22

Will Community Pharmacy Have to Change to Survive?

It seems that pharmacy takes one step forward and then two steps back. Perhaps the same can be said for NCAP, although I hope it is two steps forward and one step back. Loyd V. Allen, Jr., PhD, RPh, edits an online compounding newsletter at newsletter@compoundingtoday.com. In his January 26, 2007 edition he talked about working with pharmacy students today:

"One area of concern I see for the future in pharmacy schools across the nation, however, is that many students (1) are not active in professional organizations, (2) are active while in school to put it on their résumé to help get a job after graduation and then plan on dropping their membership(s), or (3) may actually plan on continuing their activity in the professional organization(s) after graduation.

The students who rotate through our organization discuss how many students express that they don't really care about doing anything but making money; they have no real dedication to the profession of pharmacy. In other words, they view their degree and license as simply a ticket to making a good living in the future but don't plan on putting anything back in to the profession.

Maybe I'm wrong, but I don't really view these upcoming pharmacists as dedicated professionals but as jobholders or workers taking advantage of the efforts of many others that spend time working to enhance and protect the practice of pharmacy."

I don't know if Dr. Allen's observations are right. It could explain why NCAP has trouble getting new graduates to continue their NCAP membership. When will we learn that, as employee pharmacists, we need to support an organization that is taking care of the profession? The profession of pharmacy does not take care of itself, and most pharmacy employers are not taking care of the profession either.

On another front, 2007 will bring another dispensing fee battle. Why has CMS not listened to pharmacy's message about AMP calculation? If the proposed AMP rule is implemented on July 1, 2007, many community pharmacies will be reimbursed for the product cost below what they paid for it. How long can you stay viable in that type of business environment?

Loyd Allen's January 19, 2007 editorial focused on how easy it is to misrepresent the facts as we try to make our point. He offers this insight on common misrepresentation:

"Let's set the record straight!" generally means I am going to tell you my opinion, and I want you to accept it because I am right.

"Let's look at the facts!" generally means I have selected certain items that I believe are close enough to the truth that you will probably accept them and not question them. Then I can build on that and take you where I want you to go.

"Let's be honest about this!" generally means I am going to give you a combination of truthful and untruthful information in order to persuade you to accept my opinion.

"Scientific studies show that..." means that I read somewhere (newspaper, television, magazine, and sometimes even a scientific journal) that this is true. However, as we all know that when looking at what scientific studies show, one cannot take a single study, or even select a few studies, one must look at ALL studies and evaluate them to see what is fact and what is not. Just look at all the reversals that have occurred in the scientific and medical literature over the past 10 years and look at the reversals of approved drugs by the FDA. One sometimes wonders about the real value of "scientific studies." Admittedly, they are the best thing we have going, but they can be flawed and present information in a slanted way to try to prove or disprove a point for a number of reasons, whether it is to get more grant money, to get a product approved and on the market, or just for egotistical reasons.

"I'd like to present an unbiased view on..." is interesting. Is the unbiased view coming from the speaker's presentation of information on both sides of the question? Or, is the speaker telling you that the information being presented was originally published by authors that are unbiased? The latter would be extremely difficult to prove. The former is a naïve statement because one cannot really present "unbiased" information. What we present, either in print or other media, is our "opinion" and the way we view things. Our views are developed from our beliefs, our environment, our parents, our friends, our experiences, and our attitudes.

As much as I wish there was total honesty in politics and in the scientific world, I realize that is probably not going to happen. But, we can be aware of the pitfalls and only believe what we hear and read after we have "checked it all out" ourselves. I hope I have "set the record straight!"

As we listen to the Medicaid dispensing fee discussions over the next few months keep these insights in mind. NCAP will be there, working with our legislative colleagues, promoting pharmacy's message. I hope CMS or the Legislature will hear us.

As we try to win the cost to dispense a prescription battle, should we begin asking ourselves whether we are really fighting the wrong war? Has the drug product just become a commodity and, therefore, pharmacists need to start getting paid for the drug therapy outcomes they produce, not just the distribution of a drug product? I plan to begin raising this question as I interact with the profession both locally and nationally. We may have to change the discussion if we want to save community pharmacy because apparently, decision-makers are not buying what we are telling them now. I hope I am wrong.

In this issue we focus on one of these new opportunities for a different pharmacy business model- Medication Therapy Management. NCAP, through its MTM Task Force, will help develop MTM opportunities for North Carolina Pharmacists. This may be a chance to help change the pharmacy business model, but pharmacists will have to get involved. NCAP will be there to help.

Fred Eckel, RPh
Executive Director

Dear NCAP Member,

How many times in recent years have you heard the remark, *"The pharmacy profession is at a crossroads?"* Many have used this phrase to describe the situation that we pharmacists find ourselves in today where we can go in one direction to the land of opportunity and prosperity, or we can go in the other direction where we will find ourselves essentially turning our profession over to other healthcare professionals and PBMs. Or perhaps you are familiar with Jim Collins' Good to Great bus analogy. For some it appears to be a decision of whether to get on the bus or not. Of course, if you get on, you have to make sure you're on the right bus, in the right seat, and going in the right direction! Regardless of the analogy, the message is simple...we can stand on the street corner and watch the bus go by, or we can get on board and drive it to the land of opportunity. The choice is ours to make, and for me, it is a simple choice.

If you agree that pharmacy is at a crossroads, what role do you currently play or will you play in determining which path to take? Will you watch from the sidewalk or get on the bus and help chart the course for the future of our profession? NCAP is committed to ensuring that North Carolina pharmacy is not only positioned for the future, but is creating the future. Over 36 NCAP leaders recently convened at the Institute of Pharmacy in Chapel Hill to outline a three-year strategic plan for NCAP. In the coming months, the Board of Directors will further develop or direct the development of action plans for the following critical issues and respective goals identified during the planning session.

CRITICAL ISSUE 1: How does NCAP build proactive strategic partners, collaborations and alliances with external communities to benefit NCAP and its societies?

Objective 1.1 Identify NCAP liaisons to develop and foster relationships with: legislative/regulatory, allied health, business development, education, reimbursement groups, and patients.

CRITICAL ISSUE 2: How do we best advocate the value of the pharmacist to our internal and external communities?

Objective 2.1 Investigate web-based mechanisms that promote the value of the pharmacist to the public. Develop "Value of Pharmacist" web page targeted to patient/consumer organizations through national partners.

Objective 2.2 Develop a web page advocating the value and various roles of pharmacists; send link to all licensed North Carolina pharmacists.

CRITICAL ISSUE 3: How do we create/promote a new sustainable practice model(s) that reimburses/recognizes pharmacist services for ensuring safe and appropriate use of medications?

Objective 3.1 Develop a position paper on fee structures for reimbursement of various services.

Objective 3.2 Publish and promote a registry of NCAP member pharmacists who have recognized skills in a selected practice to serve as a resource to members, other healthcare providers and payers.

Objective 3.3 Develop or provide access to toolkits for provision of innovative pharmacist-delivered care, including medication therapy management (MTM).

CRITICAL ISSUE 4: How do we create an organization that attracts/benefits all pharmacists in our state to create a community of pharmacists in the State?

Objective 4.1 Identify priority interests of and benefits desired by all pharmacists in North Carolina; develop and implement a plan for addressing those interests and needs.

Objective 4.2 Identify, develop and implement new approaches to continuing education, such as pod casts, downloadable CE, etc.

Objective 4.3 Develop new methods/approaches to communicating ways to get involved, the benefits, and what NCAP is doing now and in the future.

CRITICAL ISSUE 5: How do we develop leaders to assure the continued advancement of NC pharmacy?

Objective 5.1 Find ways to engage senior practitioners to become re-involved in NCAP to help newer practitioners within Practice Forums grow and develop.

Objective 5.2 Continue to support new practitioners and students by identifying potential leaders, and create avenues for leadership roles and leadership development.

When I reflect on why I became a pharmacist, I'm sure it is for reasons very similar to yours...wanted to get into healthcare, liked working with and helping people. Having spent my formative years in an independent community pharmacy, I had the opportunity to learn what it really means to care for people and, not only be part of a community, but also contribute to the community. When I reflect on my role as a pharmacist and my passion for the profession, I am reminded of these deeply rooted lessons. The setting may be different, but the mission is the same.

It is the sole interest of this community of 36 committed pharmacy leaders to execute a strategic plan which will support our mission of advancing North Carolina pharmacy. This is your invitation to join us in getting on the bus and charting the course! If one of these critical issues is particularly important to you or you would like to get involved, please let us know by calling NCAP, contacting us via the Web site or sending an email to me (bewillia@wfubmc.edu) or Fred Eckel (fred@ncpharmacists.org).

Beth Williams, Pharm D, BCPS
President

...applying drug knowledge to improve health

MTM

A New Opportunity You Can't Afford to Ignore

An Overview of MTM

by Joan Settlemyer, PharmD
Clinical Assitant Professor
Director of Pharmacotherapy
Charlotte AHEC

Beginning in January 2006, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) not only provided prescription drug coverage for Medicare-eligible patients, but also included provisions for medication therapy management (MTM) services. [1] Although Medicare has been in existence since 1965 there has been no widespread prescription drug coverage until MMA 2003 created Medicare Part D. (See Table 1)

Table 1

Medicare Program Components	
Part A	hospital insurance
Part B	supplemental medical insurance
Part C	Medicare managed plans "Medicare Advantage" or "MA" plans
Part D	prescription drug benefit and medication therapy management services

The new prescription drug benefit is administered by private health insurance plans that are approved by the Centers for Medicare and Medicaid Services (CMS). MMA 2003 requires these insurance plans to develop MTM services and to pay for these services for targeted beneficiaries with all of the following: (1) multiple chronic diseases, (2) taking multiple medications, (3) expected to incur prescription drug expenses of at least $4000 in 2007. The statute recognizes pharmacists as providers of MTM services, thus establishing pharmacists as Medicare providers at some level. While other providers are eligible to provide MTM services, only pharmacists are specifically identified, which represents a valuable opportunity to enhance pharmacists' role as a member of the healthcare team. Payment for MTM services is provided through the Pharmacy Drug Plans (PDPs), not CMS. In addition, the targeted beneficiary is not responsible for any direct cost sharing of the MTM service provided by their plan and enrollees will not be charged separate feés for the service.

What Are The Requirements For MTM Services?

Although the recommendation was made for CMS to define minimum requirements for MTM services, they decided against this. CMS stated in its final regulation that, "insufficient standards and performance measures exist at this time to support further government specification concerning MTM services and service-level requirements."[1] The rationale for not providing minimum standards by CMS was to allow pharmacists to develop their own innovative approaches to patient-centered services in order to improve patient outcomes. It is the hope of CMS that MTM will become a cornerstone of the Medicare Part D and will evolve to provide a range of services, from simple to complex. However, pharmacy organizations felt the need to clarify the issue of what constitutes MTM services for the profession. Under the coordination of the American Pharmacists Association, eleven national pharmacy organizations developed a consensus definition for MTM services in July 2004. [2] According to the definition, MTM services are "a distinct service or group of services that optimize therapeutic outcomes for individual patients. MTM services are independent of, but can occur in conjunction with, the provision of a medication product." Other key elements of the definition are that the services should be patient specific and preferably provided face-to-face with the goal of improving continuity of care and patient outcomes.

Core Elements of MTM

Following the establishment of a consensus definition of MTM services, APhA and the National Association of Chain Drug Stores (NACDS) Foundation constructed a model framework for community pharmacists to implement MTM services.[3] In this model, the patient has one annual comprehensive medication review with the pharmacist and follow-up visits as needed. The total number of visits with the pharmacist on an annual basis will be determined by the complexity of the patient's medication regimen, the severity of the patient's comorbidities, and the extent of the patient's health plan. (For example, in 2006, the majority of PDPs in North Carolina only paid for one or two visits per year). The goal of the comprehensive medication review and follow-up is to identify, resolve, and prevent medication-related adverse events and improve patients' medication outcomes. Although the basic framework for community pharmacy MTM services includes only five elements (see Table 2), the pharmacist may offer other MTM services, such as disease state management, health and wellness services, and coordinating medication management with other healthcare services.

The advent of MTM services through

Table 2[3]

Core Components of MTM Services in Community Pharmacy
• medication therapy review
• a personal medication record
• a medication action plan
• intervention and referral
• documentation and follow-up

MMA 2003 has given pharmacists the opportunity to reengineer the profession and be recognized as medication management leaders in order to enhance patient outcomes. Although the current program design is not perfect, MTM is an opportunity that pharmacists can not afford to ignore.

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2. Bluml BM. Definition of Medication Therapy Management: Development of Professionwide Consensus. *J Am Pharm Assoc.* 2005;45:566-572.
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Opportunities Abound

by Bryan Bray, PharmD, CPP
Chief Operating Officer
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Vice President, Piedmont Pharmaceutical Care Network, LLC

Nearly four years ago, I had the opportunity to leave my position as the lead consultant pharmacist with a long-term care pharmacy and start a practice that provided only clinical services. Medication Therapy Management (MTM) and other clinical services are important to my practice because they are the sole source of revenue. This new practice began as I became a Clinical Pharmacist Practitioner (CPP) and became embedded in a physician practice as a physician extender providing collaborative drug therapy management in the form of anticoagulation, diabetes, hypertension, hyperlipidemia, osteoporosis and polypharmacy management services. Initially, the reimbursement for these services sustained the financial viability of the practice. It successfully grew from one physician practice to currently three physician practices. Because of the development of limitations on such reimbursement in a physician practice, the need to diversify the practice became evident. As part of the diversification process, my practice also provides MTM services in the form of the APhA Foundation's replication of the "Asheville Project" known as the Patient Self-Management Program (PSMP). These services (diabetes and cardiovascular health) are contracted with large employers with self-funded insurance. These employers benefit financially the most from the healthcare cost savings. The contracting mechanism is a network of clinical pharmacists in North Carolina known as the Piedmont Pharmaceutical Care Network, LLC (PPCN). Additional services provided by my practice include outpatient anticoagulation management services for several home healthcare agencies.

During this time, the legislation regarding Medicare Part D was passed and in reality became the definition of Medication Therapy Management. This further fueled the confusion regarding the definition or terminology of the provision of cognitive services provided by a pharmacist. We also have terms such as disease management, pharmaceutical care and collaborative practice to name a few. For my practice setting, I see the need to differentiate collaborative drug therapy management (CPP services) from Medication Therapy Management and disease management.

In its initial phase, the Prescription Drug Plans (PDPs) under Medicare Part D were not given any guidelines for the development and provision of MTM services by CMS and for the most part, it was an unfunded mandate leading to the majority of the PDPs to employ practitioners other than pharmacists (nurses, case managers) to provide such services. In most cases, these services were not local-based, patient-focused, but provided as part of a population-based, telephonic call center at the PDP level. Additionally, there is a mis-alignment of financial incentives. For example, the PDPs are at most risk for increasing drug expenditures. As evidenced by the "Asheville Project," drug expenditures may often increase in an MTM program. While there is overall healthcare savings (due to the reduction of hospitalizations, unnecessary physician visits and tests), the PDP does not recognize the savings. Therefore, up to this point in time, contracting with a PDP has not been a focus of our practice.

The Pharmacist Services Technical Advisory Coalition (PSTAC) is a collaboration of the national pharmacy organizations and was established to improve the coding infrastructure necessary to support billing for pharmacists' professional services. The coalition was successful in getting the American Medical Association CPT Editorial Panel to approve three CPT codes for pharmacists to use to bill third-party payers when providing MTM. These codes can be used to bill any health plan (not just PDPs) and are pharmacist specific. However, these codes were initially approved as Category III codes which are temporary codes, thereby limiting the plan's willingness to reimburse. It was requested that there needed to be more evidence of wide-spread provision and use of such MTM services. PSTAC has successfully collected data regarding the national provision of MTM services and plans to appeal to the CPT Editorial Panel in the near future to convert these codes to Category I, which will be permanent. This will hopefully push more health plans to cover such pharmacist services.

The technology to document and bill MTM services can also be a barrier to provide such services. There are several programs nationally including Assurance, QARx and CommunityMTM. Depending on the payer or the process of care, there may be a requirement to use different combinations of these or none at all. The electronic medical record technology needs to be chosen by the pharmacist and not dictated by the payer as long as the electronic billing process is consistent. However, the electronic medical record needs to be able to collect outcomes data regarding quality of care measures. Currently, there is a national debate over use of the HCFA 1500 format vs. NCPDP format for electronic billing. CMS initially indicated that the HCFA 1500 format is the only HIPAA compliant mechanism for billing pharmacist's professional services, consistent with all other healthcare providers.

Though MTM is now a well-known concept within the profession of pharmacy, it is still novel to many other health care professions and largely foreign to the general public as the perception of pharmacists is largely that of a dispensing only role. Additionally, from a commercial standpoint, there are limited available and identifiable resources (pharmacists) to establish face-to-face, patient specific MTM programs on a scalable basis. Payers have expressed a concern over differentiating competent pharmacist providers. Certainly from the Clinical Pharmacist Practitioner standpoint additional competencies are required for registration with the Medical Board to practice. However, from the MTM standpoint, it becomes

much more difficult to consistently warrant such competencies. PPCN has established a model that is successfully solving the challenges listed above on a local basis. It is organized as an Independent Provider Association (IPA). It identifies and credentials competent practitioners and contracts with them to apply specific protocols for referred patients. It then contracts with organizations to deliver care to employees or beneficiaries who stand most to benefit from those services. Providers are paid by PPCN who collects from the customer organization. PPCN has developed a proprietary credentialing process that includes the AHEC provided, ACPE-approved certification programs as well as the various national certifications (BCPS, CGP) and residencies. This has helped payers recognize consistency in the credentialing process, competent pharmacist providers and thus, process of care.

Several factors are driving forces to the future of MTM. Leading the charge is the difficulty business and governmental agencies have in continuing to afford funding for healthcare and drug benefit plans with expenditures for pharmaceuticals. Additional drivers include the rapid introduction of new drug products to the market and the aging demographics. For every dollar spent on a medication, an additional dollar is spent on treating an adverse consequence of that medication or for improper use of the medication. Because of this, the future for MTM opportunities looks very bright.

MTM: Long-Term Care Considerations

by Ken Tuell, RPh, CGP
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Much has been written about and much has been expected from the provision in the Medicare Modernization Act (MMA) that mandates Medication Therapy Management, or MTM, for beneficiaries of the new Medicare Drug Benefit (Med D) that began in 2006. The provision is designed to improve medication use and reduce the risk of adverse events (AEs). Also, this provision within the benefit is to be provided by the Plan Sponsors, those entities contracted by CMS to administer the prescription benefit. We now have a full year under our belts, and from the perspective of prescription claims, beneficiary enrollment and beneficiary status (LIS, Dual Eligible, MA-PD etc.), hopefully (!), things will be smoother in 2007. As far as MTM in the ambulatory setting is concerned though, the success stories are slowly trickling in. Hopefully, as more pharmacists and pharmacies continue to develop a comfort zone and a process for community-based MTM, those success stories will become more widespread.

A distinction that was made in the language in the regulation was the requirement for the provision of MTM services for those beneficiaries in ambulatory AND *institutionalized* settings. Also, language in the MMA states that Plans may "distinguish between services (MTM services) in ambulatory and institutionalized settings." One must remember that all institutionalized qualified beneficiaries of Med D are not residing in SNFs, or Skilled Nursing Facilities. There are many other settings of an "institutionalized" nature, where these beneficiaries reside, such as Assisted Living, Group Homes, etc., some of which do not have a drug review requirement, but meet the definition of an institutional setting. As we know there have been regulations requiring a monthly Drug Regimen Review (DRR: now called Medication Regimen Review-MRR) in the SNF setting since the 1980's. The pharmacist that typically provides this service is referred to as the Consulting Pharmacist (CPh). Through the efforts of ASCP (American Society of Consultant Pharmacists) and its research program called the Fleetwood Project, the benefits of this monthly MRR have been substantiated. Other articles and programs have also shown the benefits of a routine, pharmacist-driven oversight program in other settings. Perhaps this was the impetus for the requirement for MTM services within the Med D program to begin with. But, to *specifically* mandate this service in a setting where it is already going on...why?

The plan sponsors are required to provide the MTM services, and network pharmacies, whether retail pharmacies or closed-door long-term care pharmacies, are being contracted by the various plans to provide this service. The provision of MTM services is NOT a part of the dispensing fees paid to the pharmacies. Except where prohibited by State regulation, most often the DRR/MRR services in the institutional setting have been provided by the CPhs employed by the long-term care pharmacy providers contracted by the facility. So, in this case, the Plans will be contracting with Pharmacies that are *already* providing a type of MTM...called MRR. But, where does the "distinguishing" part come in, so that it is viewed as "distinct and different?"

The first "distinction" is that the MRR is mandated and overseen by the Federal government through regulations and by departments responsible for the provision of ALL services being provided to the residents of SNF's and some other settings, commonly called the OBRA Guidelines. These regulations are written without regard as to who is paying for the various services, including the MRR. The payment for this "room and board" does not specifically include payment for any pharmacist MRR services. The predominant payer of the "stay" in the SNF setting is the state Medicaid program. Prior to the implementation of the MMA and the Med D program, Medicaid was the predominant payer for the pharmaceuticals utilized in this population as well, and Medicaid did not pay for the MRR. The requirement for MTM in the MMA is on the Plan sponsor, or payer, of the prescription benefit, and the *cost* of MTM is to be borne by the Plan. MTM is under the area in the provision that deals with cost control and quality improvement. Therefore, the Plan is required to develop and, therefore, pay for MTM services in a setting where an MRR process possibly already exists.

Secondly, the regulations steering the MRR process, with oversight driven through what is called the State Operations Manual (SOM), are written by CMS and encompass many different areas distinct to the overall provision of pharmacy services to a facility. The process, the responsibility being those of a CPh, requires the CPh to be responsible for oversight for all pharmacy services and the coordination with other healthcare providers in the facility. Plan-sponsored MTM in LTC, however, is specifically driven by the *Plan* that the beneficiary/resident chooses, and the subsequent goals of that plan fall within the mandated areas of cost control and quality improvement, resultant to the prescription claims received by the Plan for that beneficiary/resident. The plan will provide clinical and financial considerations to be reviewed for that beneficiary/resident. Optimally, this process is through the services of the

CPh familiar with the residents, and has the resident's medical chart available, as well as a relationship with the prescribers.

However, some plans are not delivering this service for LTC beneficiaries through a pharmacist. Some plans are sending MTM considerations directly to the prescribers, who in the case of the LTC beneficiary do not have the full patient medical history (chart) at their office. Due to the nature of polypharmacy in the typical institutionalized resident (avg. 9 prescriptions/month), the most appropriate course for this intervention would be through the CPh while he/she is at the facility with the residents' charts, and with access to other caregivers. Hopefully, all plans will recognize the ongoing relationship the CPh has within the provision of the pharmacy benefit and will seek out ways to drive their MTM efforts in LTC through the Consultant Pharmacists.

As with the ambulatory setting, MTM in LTC has many faces and methodologies at the present time. It is another way, though, that pharmacists serving an institutional setting can prove their value to the parties paying the tab, i.e. the plans. Pharmacists should seek out contacts within the plans that serve their residents in the buildings in which they have consulting responsibility. Find out what their MTM plans are and discuss with them the value you can provide to them and their beneficiaries. This is a prime opportunity to prove to plans the value of pharmacy consultation.

Capable People in an Incapable System: MTM Services for the Masses

by Troy Trygstad, PharmD, MBA, PhD
Independent Pharmacy Consultant

Consider the following statements that were made to me recently by two very well meaning, pro-pharmacist physicians:

Physician A: ***"Pharmacists are the most over trained people in the entire healthcare system."***

Physician B: ***"Pharmacists are the greatest untapped resource in the healthcare system."***

Two sides of the same coin. The difference in perspective lies in their practice experience with pharmacists, or lack thereof.

Physician A is a general practitioner. His perspective, like that of many physicians, was formed largely by his experience of waiting in line at the pharmacy check-out counter. From his vantage point, the pharmacist is continuously engaged in unending, seemingly menial tasks, with little time or desire to provide pharmaceutical care. Although nearing the end of a long practice career, he claims never to have interacted substantively with a pharmacist in the course of caring for one of his patients. Given his frame of reference, should we be surprised that his view of pharmacy practice is so limited in scope?

In contrast, physician B maintains a more expansive vision of pharmacy practice. As a geriatrician, he has developed longstanding relationships with pharmacists through years of collaboration. His vision was nurtured in the institutional setting, first by Drug Regimen Review requirements, and then by clinical pharmacists at an academic medical center. Physician B has acquired a level of comfort with an expanded scope of pharmacy practice and maintains a clear vision of how it can enhance his own practice.

As the perspective of the prescriber goes, so goes the success of the Medication Therapy Management Services for the masses. Both physicians hold pharmacist capabilities in high regard. Yet, only the geriatrician maintains a vision of pharmacist-physician collaboration that transcends the dispensing role of the pharmacist. Unfortunately, geriatricians are in relatively short supply. Despite the valiant efforts of many progressive pharmacies, the perception of the capable pharmacist working within an incapable system remains.

Developing *Meaningful* Relationships with Prescribers

In my own view, developing meaningful relationships with prescribers, regardless of their training (MD, DO, NP, PA, or CPP) is the single most important near-term task for progressive pharmacy practice. Prescribers who have meaningful working relationships with pharmacists generally hold a different perspective on pharmacy practice. I work quite happily as a part-time pharmacist for a very large retail chain. Yet I do not maintain a single meaningful working relationship with any prescribers aside from the obligatory trading of faxes for refills or clarification of medication orders with the prescriber's nurse.

On a recent visit to a very large family practice center, I was struck by the number of prescribers listed in the lobby for whom I had likely filled thousands of prescriptions. Yet, I could not identify a single one of them in a line-up had my life depended on it.

What is the likelihood of a Medication Therapy Management Service receiving due attention from the prescriber if I have never met nor spoken directly to the prescriber(s) of interest? What value should the prescriber place upon my recommendations if her perception of me is limited to observations while waiting in line at the pharmacy? As a profession, we need to develop with prescribers a level of discourse and acumen commensurate with the level of service we desire to provide.

Developing Efficient and Effective Means of Communicating with Prescribers

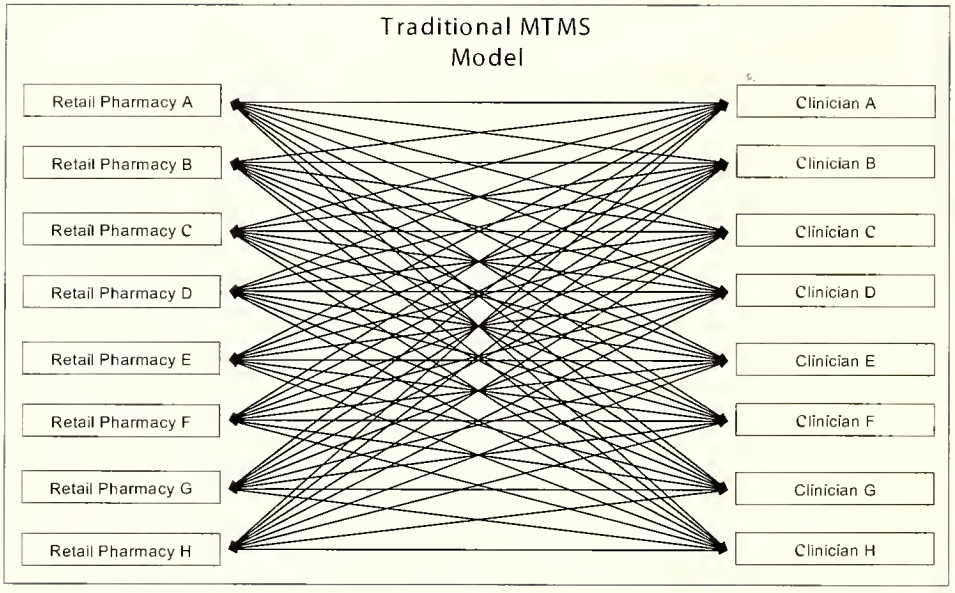
One of the more challenging barriers to the development of working relationships with prescribers is the growing volume of requests for external input. Put yourself in the shoes of a prescriber for a moment. At the end of a day, not unlike ours, filled mostly with paperwork, dictation, insurance problems, support staff who call in sick, listening to companies selling products, and altogether too little time to interact with patients, you pick up a fax from presumably a very capable pharmacist, whom you've never met amongst an array of prior authorization requests, refill requests, dear doctor letters, and medication therapy management recommendations from a number of other pharmacies. Just as pharmacists do, you triage the requests based upon the most time-sensitive responses.

How time-sensitive is the pharmacist review? Is there a downside to ignoring the review altogether? What's more, you may not see the patient for whom the MTMS recommendations were made until next month, or even the month following. How would you respond to the MTMS recommendations?

For the most part, we operate in a fractured health care system full of silos, with little integration across settings. The left

hand is rarely coordinated with the right hand. To successfully engage the prescriber, progressive pharmacists must develop more efficient and effective communication models that work seamlessly with prescriber practice workflow.

Consider the following illustration of a retail-based MTMS program and the communication lines between pharmacist and prescriber:



Now imagine that there are multiple MTMS programs from multiple third-party prescription payers that all operate differently and with different forms and rules so that we end up with a model that is three dimensional and layered 40 to 50 times deep (For 2007, there are 51 Part D plans in North Carolina alone, all of which are required to eventually provide MTMS services of some type). What's worse, there may be only 5-10 patients in each pharmacy for each program, creating the most problematic barrier of all to a successful progressive pharmacy practice--limited economy of scale.

Why We Are Where We Are: The MTMS Loss-Leader and the 20/80 Rule

Most clinical pharmacists today have salaries that are subsidized by academic medical centers or other institutional supporters of clinical pharmacy. Rare is the non-subsidized pharmacist making a living providing MTMS services entirely removed the sale of drug products. This fact leads me to believe that MTMS services are, in general, a loss-leader for most retail pharmacies.

Complex patients using multiple medications are essential to the retail pharmacy's bottom line. If they were not, why would there be such widespread acceptance of Medicare Part D contracts in the face of incredibly low reimbursement rates? These patients have a legitimate unmet need for MTMS services. Providing an MTMS service to them may cause a short-term loss to the pharmacy from increased payroll, but effectively operates as a lead to filling multiple chronic medications on a regular basis.

This loss-leader scenario for MTMS services is worrisome given the previous discussion about the perspective of the prescriber. If the rationale for providing MTMS services is to preserve prescription volume, of what quality will the MTMS service be? What perverse incentives exist? How many pharmacies truly desire to provide these services? Perhaps 20 percent do and 80 percent do not.

In the retail setting, I am perfectly content with my role as a dispensing pharmacist that provides valuable advice to patients with a variety of needs in 15 to 30 second increments with the occasional extended consultation. My pharmacy provides the right drug to the right person at the right dose in a timely fashion at an incredibly affordable price. In other words, it functions exactly as designed. Does it make sense for my pharmacy to be on the leading edge of pharmaceutical care? Perhaps not. Does it make sense for the pharmacist? Perhaps it does.

Matching *Willing* Pharmacists with *Willing* Prescribers

What if the service was completely dissociated from the product? That is, what if the pharmacy could keep the patient's dispensing business while at the same time covering the MTMS needs of it customers through a pharmacist who specifically deals with MTMS reviews and is not beholden to the sale of the product?

Would the perception of pharmacy change in the minds of prescribers if 1) the pharmacist and his/her actions were independent from the pharmacy? and 2) willing pharmacists could be matched with willing providers so that meaningful relationships have a chance to evolve?

Consider the "MTMS Model With Clear Lines of Communication and a Feasible Number of Working Relationships" on page 11.

As MTMS programs evolve across the country, program administrators are faced with a choice: Many interventions by the few or few interventions by the many. I suspect that prescribers prefer the former. I cannot know the real ratio of willing to unwilling pharmacists, and the market is likely to make the ultimate determination, but MTMS economies of scale along with a fractured and convoluted health care system prevent the entire lot of us from partaking in successful MTMS services. And perhaps that is for the better considering that something less than the whole wants to.

MTM Services at Spindale Drug Co. and Spindale Long Term Care Pharmacy

by Lesley Harmon Koonce, RPh
Pharmacist and Co-owner of Spindale Drug Company and
Spindale Long Term Care Pharmacy

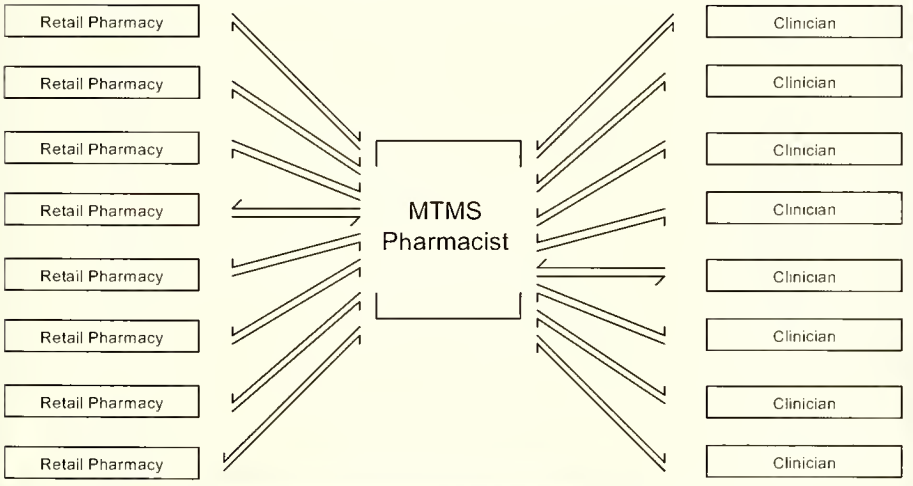
Our primary mission at Spindale Drug Company is to make a difference in the lives of each patient who enters our doors. Our focus as pharmacists is to offer services to measurably increase positive health outcomes that result in the best patient care. As independent pharmacists, our patients have come to expect reliable health information along with personal medication recommendations. It is exciting to finally receive validation from private and public payers who are beginning to recognize the value of this

vital component of patient healthcare.

As owners and pharmacists of a traditional independent pharmacy, Spindale Drug Company, and a closed-door long-term care pharmacy serving assisted living patients, Spindale Long Term Care Pharmacy, we clearly see the need for our assistance in managing the complex medication regimens. Our senior patient population often comes to us overwhelmed and confused with the multiple medications required to address each part of their chronic disease processes. We have all too often seen the hospital admissions that result from an inappropriate medication regimen or noncompliance with the regimen. While MTM is the basis for ensuring optimal patient health and wellbeing, it has become equally important to sustain a viable pharmacy business.

In 2006, Medicare Part D further increased those "sticker shock moments" that all community pharmacists suffer as we review the electronic claims and pound our fist on the counter in disbelief. For our pharmacy, this was the final impetus for us to seek a method to receive a fair market rate for a service we had essentially began giving away. Medicare Part D significantly increased the time required to fill a typical prescription due to the numerous formulary restrictions and, therefore, began to limit the time available to our patients. However, our patients required even more of our time as they needed assistance in finding appropriate alternative medications that would be covered by their Part D plan and, in finding medication alternatives to lessen the financial burdens. We were aware that many plans offered MTM as part of their Part D plans however, most of these services were simply pharmacy benefit call centers cloaked in the MTM rhetoric with an ultimate goal of self-seeking profits. We continued to read and study the options available to offer true patient care that would fully utilize our skills and ensure that our patients would receive the maximum benefit. Finally, in the latter stage of the year we began to implement the web-based system offered by Community MTM through Community Care Rx. After enrolling our pharmacy and completing the training program we began to call our patients to notify them of the service available to them as part of their prescription plan and to schedule appointments. While some cases may necessitate that the process be conducted through a phone call followed by a mailed written correspondence, we believe the best way to fully understand our patients' needs and ensure compliance requires a face-to-face appointment in the pharmacy. Our patients need a quiet, private space where they can bring in the "brown bag of bottles" and we can truly begin a dialogue. The CCRx program provides a guided instruction to assist us in identifying duplicate therapies, potential drug interactions and potential cost savings. It also provides an easy format to document the review and submit a bill for our service. Overall we are pleased with the CCRx format but hope to see some changes for improvements. First, the program does not allow flexibility in the completion of the review for issues that may be uncovered during the review that are not flagged by the program. Secondly, we believe that we should be able to identify potential MTM patients ourselves rather than simply waiting for notification that the PDP plan has determined a patient has "qualified." Many times we see extenuating circumstances that should be considered in determining who could most benefit from the MTM service. As pharmacists, we realize the value of the preventive approach in saving healthcare dollars and lives and we should be trusted to make those judgments. Finally, we are convinced that the plan should cover additional sessions to ensure that we are helping patients progress in their compliance and further their understanding of the ongoing commitment required to maintain optimal medication results.

MTMS Model with Clear Lines of Communication and a Feasible Number of Working Relationships



After surviving the tidal wave that came crashing into our pharmacy in January 2006, known as Medicare D, we anticipate more fully expanding our MTM services in 2007. We will continue to work with NC Medicaid, CCRx and perhaps a few other pharmacy plans to offer the patient care our patients deserve. To more fully implement MTM services we have made changes in our staffing schedules and work flow planning. We schedule appoint times when we know we will have greater pharmacist and pharmacy technician coverage. We have also begun training our technicians to assist in completing the reviews. Currently they assist in scheduling appointments and in reviewing the initial data to determine if the medication regimen is accurate and complete when compared to our data. Also, we have increased the responsibilities for the certified pharmacy technicians to include explanations of potential cost savings to our patients at the time of the initial fill of the prescription. This results in cost savings much earlier and increases the likelihood that we may be able to keep our patients from hitting the "coverage gap."

Along with our Medicare Part D Patient MTM opportunities and a renewed commitment to patient care, we are determined to be an independent pharmacy that will weather the changing winds and be a part of the era that impacts patients' lives as never before. We hope to encourage other pharmacists, who may have been resistant, to begin MTM services to realize the value this can bring to their patients and to the future of our great profession. **Rx**

Building Collaborative Relationships With Physicians

by John Clark, PharmD

As community pharmacy practice evolves to offer reimbursement for pharmaceutical care services such as medication therapy management and immunizations, many community pharmacists wonder how to effectively develop collaborative practice relationships with other health care professionals. For myself and many other pharmacists, the phrase "collaborative relationship" or "collaborative practice agreement" creates apprehension because the practitioner you approach may reject your efforts to work with you. Fortunately, authors Randall McDonough and William Doucette realize the value of collaborative relationships to all parties involved and have written a chapter in A Practical Guide to Pharmaceutical Care to put the fear of rejection into perspective and give pharmacists a framework for assessing and developing collaborative relationships.

McDonough and Doucette contend that there are five progressive stages in the development of collaborative relationships. The five stages are:

Stage 0 – Professional Awareness
Stage 1 – Professional Recognition
Stage 2 – Exploration and Trial
Stage 3 – Professional Relationship Expansion
Stage 4 – Commitment to the Collaborative Working Relationship

Activities in Stage 0 include things like calling physicians for refill requests or alerting physicians to inappropriate dosages or adverse reactions. Interaction is minimal and neither party thinks of enhancing patient care through a collaborative practice agreement. McDonough and Doucette use only whole numbers to classify the stages of collaborative practice agreements, but as a new pharmacy graduate (UNC-CH class of 2006) I would argue there is a Stage 0.5. At Moose Professional Pharmacy where I am a community pharmacy resident, we created a business agreement with a physician who writes phentermine prescriptions for his patients trying to lose weight. Many third parties do not cover phentermine so we created a special pricing structure for his patients taking phentermine and asked that he refer those patients to us. In exchange for his referrals, we made it clear to him that we would respond quickly to his drug information needs. He agreed to this arrangement and we now dispense approximately ten phentermine prescriptions a day. In 2007, we plan to further develop this relationship by initiating our marketing campaign for our evidence-based weight management program with this physician.

In Stage 1, the pharmacist works to sell the value he or she would add to a collaborative relationship. In this stage, the pharmacist details practitioners about the value of community based clinical services like diabetes education and medication therapy management. The practitioner may appear skeptical throughout Stage 1, but that should not discourage you because there are studies like the Asheville Project and Project: IMPACT you can use as talking points to convince the practitioner that pharmacists add value through collaborative relationships by improving outcomes and lowering health care costs. You can also cite examples of other pharmacists in North Carolina who have already developed the type of collaborative practice you want to build. In my opinion, Ron DeVizia, PharmD with Kerr Health Care Center in Zebulon, NC exemplifies a textbook example of selling the value of a pharmaceutical care service to physicians. DeVizia's desire to see a sustainable pharmacy practice that focuses on improving outcomes in diabetic patients led him to contact physicians about the best possible therapy for their diabetic patients and then use those interactions to market his ADA approved diabetes education courses.

As the collaborative relationship progresses to Stages 2 and 3, the practitioners build trust and respect as both participants make collaborative interventions and the outcomes are perceived positively. The goal of the collaborative relationship at this stage is to make your services seem irreplaceable and to directly demonstrate that community pharmacists are capable of positively affecting primary care practice. First, your patients must perceive your services as providing benefit. Secondly, physicians should be made aware of your patients' positive perceptions and any positive outcomes produced from your efforts. Faxing copies of SOAP notes created through MTM or hormone replacement consults is one quick way to keep physicians informed of the value you provide the patient.

Lastly, Stage 4 represents the actualization of a collaborative relationship. Efforts by the pharmacist and practitioner to enhance the collaborative relationship and maintain past agreements signifies the progression to Stage 4. Once a collaborative relationship is actualized, then both parties should work to develop innovative practice models to achieve the goals of improving patients' lives, lowering health care costs, and advancing the role of pharmacists in the health care delivery system.

As pharmacists, our training prepares us to manage a patient's medication regimen, but time constraints due to dispensing roles and lack of awareness by other health care professionals present two obstacles to the proactive creation of collaborative practice agreements. Medication therapy management is one of many ways to overcome these two obstacles since some third parties allow for easy to use web based data entry. A quick fax to the patient's doctor after your MTM consult draws the physician's attention to your actions and broadens your pharmacy practice. While there may be growing pains for you and the physicians because of the unnecessary fear that pharmacists want to usurp the role of physicians, the aforementioned collaborative relationship stages will assist your honest assessment of current collaborative relationships and help you develop strategic action plans for progressing through the stages. **Rx**

Fatigue, Lack of Sleep and Safety

The North Carolina Supreme Court recently ruled that the North Carolina Board of Pharmacy (NCBOP) has the right to place restrictions on the working hours of pharmacists in this state. This ruling reversed a previous Court of Appeals decision that the NCBOP did not have the right to set such guidelines. The NC Supreme Court thereby upheld Rule .2506 which stated that:

by Robert Cisneros, PhD

A permit holder shall not require a pharmacist to work longer than 12 continuous hours per work day. A pharmacist working longer than six continuous hours per work day shall be allowed during that time period to take a 30 minute meal break and one additional 15 minute break.

NCBOP's Web site (www.ncbop.org) describes the ruling and provides links to more detailed information, including the actual Supreme Court decision itself. The decision drew favorable editorial responses from at least two major North Carolina newspapers, the *Charlotte Observer* and the *Raleigh News & Observer.*

The relationship between performance and fatigue has received increased attention in recent years. Krueger wrote in *Human Error in Medicine*: "Fatigue which results from continued physical or mental activity is characterized by diminished ability to do work and is accompanied by subjective feelings of tiredness."[1(p.314)] Krueger goes on to say that fatigue due to excessive work hours over a prolonged period of time is not remedied by a simple day off. Such chronic fatigue requires a more prolonged period of rest similar to "a vacation or a change of jobs."[1(p.314)]

A common thread in many major disasters has been fatigue and the effect of lack of sleep. Stanley Coren in *Sleep Thieves* noted that the Chernobyl nuclear accident, the near disaster at Three Mile Island, the Exxon Valdez oil spill and the Challenger explosion were related.[2] In each event key decision makers were operating with minimal sleep or rest over the previous 24 hours.

> *"We now know that 24 hours without sleep or a week of sleeping four or five hours a night induces an impairment equivalent to a blood alcohol level of 0.1%. We would never say, 'This person is a great worker! He's drunk all the time!' yet we continue to celebrate people who sacrifice sleep.'"*
>
> Charles Czeisler, MD, PhD
> *Harvard Business Review*
> October, 2006 (p. 56)

Dr. William Dement, a sleep researcher, has studied the consequences of lack of sleep.[3] He noted that in the Exxon Valdez disaster the third mate who was actually at the controls of the ship had six hours of sleep over the previous 48 hours and did not notice that the auto-pilot was turned on. Thus the ship did not respond to efforts to change direction. The result was a massive oil spill. In *The Promise of Sleep* Dement described the Challenger explosion. He noted that the Human Factors Subcommittee involved in the Challenger investigation identified sleep deprivation among the NASA managers as a major cause of the flawed decision to launch.[3]

Pharmacists, Technicians are Human

As described in the Institute of Medicine's Report "To Err is Human," an important principle for creating safe systems is "Respect Human Limits in Process Design." [4(p.170)] The report noted that reliance on human vigilance for prolonged periods of time is not reasonable. Constantly having to "be on" takes a toll on an individual and can cause fatigue and tiredness. The IOM listed several aids to help including limitations on long shifts and staff rotation. A simple respect for human limitations has a dual purpose. A work environment safe for workers is safer for patients also.[4]

In the newest edition of *Medication Errors*, Smetzer and Cohen discussed fatigue and its effects on performance.[5] Over fifteen effects of fatigue were listed and included: slowed reaction time, reduced accuracy, impaired communication skills, indifference and loss of empathy, compromised problem solving and decision making, and lapses of attention and inability to stay focused.[5 (p.266-267)] Adequate scheduling and periodic breaks during a shift were two of the suggestions offered by Smetzer and Cohen to help reduce fatigue in the workplace.

Sleep Deficit

Dr. Charles Czeisler of the Harvard Medical School discussed the effect of lack of sleep on performance during an interview published in the October, 2006, issue of the *Harvard Business Review*.[6] Czeisler believes that "being 'on' around-the-clock induces a level of impairment every bit as risky as intoxication."[6(p.54)] Czeisler regards a culture of "sleepless machismo" as non-intelligent management.[6]

According to Czeisler there are several factors related to sleep which affect our levels of alertness. Normally we determine when we rest or go to bed at night. It is a routine our body becomes familiar with. However, when we are working long shifts for consecutive days with the resulting accumulation of sleep deficit our body will send us sleep signals at the wrong times, such as when we need to be awake.[6]

The cumulative effect of several nights with minimal hours of sleep can affect our alertness. According to Czeisler, several days with only about four hours or so of sleep per night can produce the same effect on our judgment as not sleeping at all for 24 hours (which is equivalent to being legally drunk). [6]

Adapting to a new shift change, regularly working different shifts (for example, day shift one week and evening or night shift the next) or traveling which entails significant time zone changes can also affect our alertness. With a regular schedule and sleep times, our body's natural biorhythm takes over. Melantonin begins to rise as we approach our normal sleep time and diminishes near our usual wake up time.[6]

Unfortunately, when our normal wake-up and sleep times constantly change, our body ends up trying to signal us for sleep when we need to stay alert and sends us wakeup signals when we need to sleep. Czeisler warns about "sleep inertia" which is that feeling of being "lost in space" we may experience upon being awakened unexpectedly. Ever had a phone call at night that awakened you from a deep sleep? Did you need a little time to orient yourself to time and place? Trying to make important decisions in such a state can be problematic, similar to trying to start a car engine on a cold day. Our brain likewise needs to warm up, otherwise poor decision making can occur.

The quality of important decisions made in the midst of fatigue, after traveling long distances or after major time zone changes may

be less than ideal. Several suggestions by Czeisler to help remedy this included a limit of no more than 12 hours per workday with a minimum of 11 consecutive hours of rest every 24 hours.

A Safe Environment

The effects of lack of sleep and overwork on performance has been documented. It is unfortunate that the health care profession traditionally has been behind most other professions in recognizing the impact of fatigue on job performance and safety.[5] NCBOP's regulation regarding working hours (currently titled 'Rule .2506') is not a case of a Board of Pharmacy trying to interfere with the practice of pharmacy. This is a case of a Board of Pharmacy trying to help create a safe environment for patients and for pharmacists. A safe pharmacy environment benefits both patient and pharmacist alike. **Rx**

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6. Czeisler,CA. (2006). Different Voice: Sleep Deficit. *Harvard Business Review*, October.

About the Author...

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Improving Quality Through Peer Review

by Kenneth R. Baker, RPh, JD

Introducing an organized quality workflow system, such as the Pharmacy Quality Commitment® Sentinel℠ workflow system, is the first step in reducing medication errors in a pharmacy. To attain maximum effectiveness, however, an additional element must be added. The pharmacy must be able to track each error and each near-miss in a manner that allows the system to continuously improve. NASPA's quality program for pharmacy incorporates its Quality Manager℠ quality related event recording for that reason.

Continuous quality improvement is the goal of every pharmacy quality system. The way to accomplish that is to introduce into the pharmacy an organized workflow with proven techniques that will reduce the likelihood of error. These techniques are pharmacy best practices, such as an NDC check. The Sentinel system of quality control, for example, uses over twenty best practices, some more than once throughout the workflow.

With the workflow in place, the next step is a program, such as the Quality Manager℠ reporting system, designed to record all quality related events, or mistakes, made while filling prescriptions. Collect and compile the data and use it to determine how the workflow can be improved. It sounds simple, but, unless the data is presented in a usable manner, it could be overwhelming.

A few rules help to keep the process of improvement easy and workable. Limit the amount of time required to collect the information. When the Quality Manager℠ was designed, it became apparent that in order to ensure it would be used, the information collected had to be limited to what could be recorded in 30 seconds or less. The more information gathered the better, but if it takes too much time to record each mistake, pharmacists and technicians in a busy pharmacy will not use the system.

For example, when NASPA's Quality Manager was tested in 25 busy pharmacies, the average time to record each mistake was twenty-three seconds. On average, pharmacies recorded one to two mistakes for each 200 prescriptions filled – a ½ to 1% quality related event (QRE) rate. At this rate, even if a pharmacy filled 500 prescriptions a day, the time required to enter all mistakes or QREs into the program would amount to less than five minutes a day.

After the data is collected, it should be presented in a visual format, such as a chart. A lot of data is nice, but for most of us, trying to make sense out of several pages of information set forth in column after column invites eye strain and an enormous headache. Presenting the same data in a graph provides a picture of the problems and allows our mind to visualize the data more quickly.

Quality related event data does not provide automatic answers. What it does do is to provide questions that can lead to answers. Peer review is the process whereby a pharmacist or a group reviews the data, asks those questions presented and then suggests solutions.

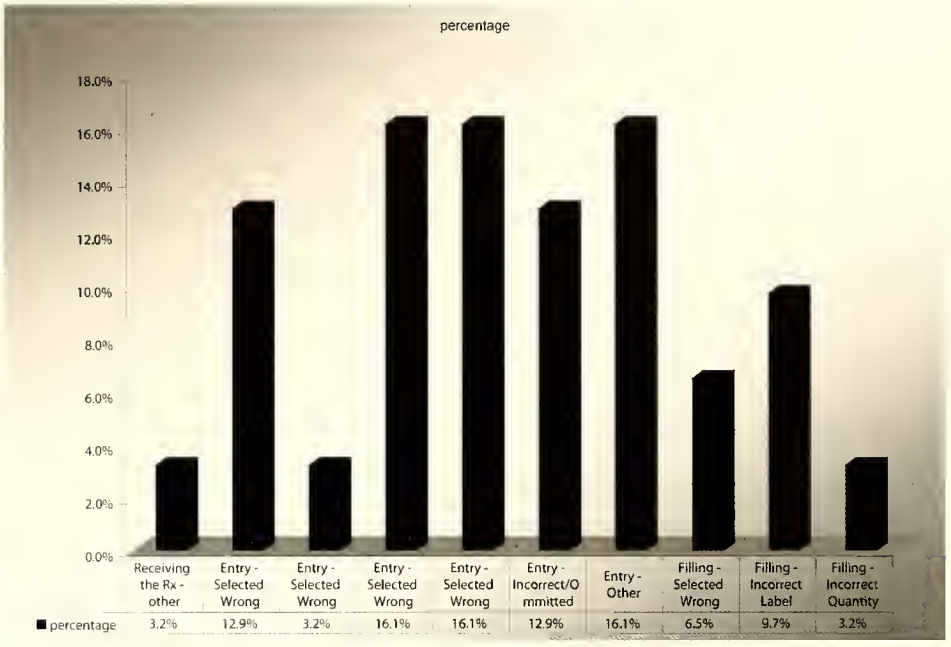
Consider the accompanying chart provided by Pharmacy Quality Commitment® from one pharmacy. In that pharmacy, we found that 77% of all of their quality related events or prescription mistakes for one month were made during computer entry. Note that there is no one area during computer entry that stands out. Several types of mistakes were made. Consider the chart

and assume this was your pharmacy. What questions come to mind that you need to investigate? What solutions might you offer?

You might suggest that for the next month the pharmacy concentrate on computer entry generally and point out at least one best practice that could either stop a QRE from occurring or would catch it before it reached the patient. First, you might suggest that the pharmacy share the information including the chart with all staff. Post the chart where the staff (not the patients) can see it. Next, the pharmacy might emphasize quality and the importance of "getting it right the first time." Consider something simple and corny - post a sign near the computer that says in large letters "CUT the 77."

Now, you might suggest one best practice designed to catch mistakes from reaching the patient. Consider using the best practice "Take 5." "Take 5" is the first step in a process, whereby the person's first job is to check what occurred in the process before. In this case, use "Take 5" in the new prescription filling process, which usually immediately follows computer entry and label generation. The person filling the prescription first takes a short amount of time (5 seconds) to compare the prescription against the label for accuracy. Are the patient's name, drug name, strength and directions correct? It has been estimated that "Take 5" will catch 95% of all mistakes occurring up to that point. One pharmacy taped a sign to the prescription counter where the filling process occurred. The sign was in four colors and in large block letters and simply said "TAKE 5." The same sign was taped on the counter in the area where the pharmacist performed the final check before bagging the prescription.

Peer review of quality data is a powerful tool. Collect the data in your pharmacy and try it for six months. The success rate will improve. One caveat when using signs as a quality reminder -after a while they tend to "fade into the background." After about 30 days, replace them with something new. **Rx**



Auxiliary Leaves Scholarships in Hands of Endowment

The former Women's Auxiliary of the North Carolina Pharmaceutical Association has liquidated their financial assets and turned the money over to the NCPhA Endowment Fund to preserve the student scholarships they established many years ago.

President Margaret Randall explained that "the organization was originally made up of wives who wanted to support their husband's profession but as more women went into the field our numbers dwindled and it became difficult to support our projects."

"We were always active in giving to the schools so we reviewed our funds and turned our account over to the Endowment so that the scholarships will be preserved," said Board member Erie Cocolas.

When the group dissolved three years ago the stock market was low so they waited before turning over $81,364.00 to be utilized for the following pharmacy student scholarships:

- The Lucille F. Rogers Scholarship, established in 1959, is awarded to a UNC Pharmacy student for not less than $1,500.00.
- The Vivian Smith Scholarship, established in 1974 is awarded to a UNC Pharmacy student for not less than $1,200.00.
- The Campbell University Pharmacy School Scholarship, established in 1991, is awarded to a CU Pharmacy student for not less than $750.00

Some member of the Women's Auxiliary gathered at the Institute of Pharmacy last year to plan an Open House for the newly renovated building. Present that day were Daphne Ashworth, Vivia Creech, Dot Moose, Ruby Creech, Peggy Jackson, Jean Morse, Erie Cocolas and Ginger Lockamy.

The former Board of Directors of the Auxiliary also gave the Endowment Fund their collection of silver. These pieces of silver were donated to the Institute of Pharmacy from various individuals and groups to be used for pharmacy functions. The silver is currently on display at the Institute.

"I'm sorry to see the Auxiliary fold because we did a lot of good things and had a lot of good times together, but times have changed," said Secretary Dot Moose.

Endowment Board member Mickey Watts noted how generous the Auxiliary has been in its contributions to NCPhA and the building fund. NCAP's Executive Director, Fred Eckel, is pleased to be able to continue the scholarship support initiated by the Auxiliary.

As the checks are written each year they will be a continual reminder of significant contributions the Auxiliary has made and the important part it plays in North Carolina Pharmacy. **Rx**

Wingate University School of Pharmacy students (l to r) Joanna Tracy, Kate Shaw, Sun Kim, Kelly Bixby, Neyosha Talebi, and Josh Rowland.

Wingate Students Share Dose of Knowledge Through Community Projects

Twice a year Wingate University's pharmacy students reach out to the community to share their knowledge on key health issues and gain practice working with the public. During the fall semester, six groups of students went out into Union and Mecklenburg counties to address topics such as poisoning in children, Pediatric Type II Diabetes, dental health in pets, hygiene and medication safety among children, osteoporosis, and the benefits of breastfeeding.

Students conducting the poison prevention project worked with the Union County Health Department, the HELP Pregnancy Crisis Center and the Aquatic Center to counsel parents on the most common household items ingested by small children.

The students also met with day care directors, parents and children at Wingate Elementary School to talk about eating habits that can lead to Pediatric Type II diabetes. Pediatric diabetes in North Carolina has risen from 4.6 percent in 1995 to 8.2 percent in 2003.

For the osteoporosis project, students provided free bone density screenings for 166 local residents and offered counseling on osteoporosis prevention.

The students visited Union Elementary School and a day care center to demonstrate the importance of germ awareness, oral hygiene and medication safety.

Another group visited agencies in Union and Mecklenburg Counties to dispel the myths of breastfeeding and point out the financial and health benefits to mother and child.

The students' pet project took them to the Humane Society in Charlotte to tell pet owners about proactive dental health and the dangers of poor oral hygiene.

Campbell Pharmacy Faculty Member Hosts Radio Show

Andy Bowman, Director of Continuing Education and Assistant Professor of Pharmacy Practice at Campbell University's School of Pharmacy, is hosting a radio show on WFNC 640AM in Fayetteville called "Ask the Pharmacist." The program, which airs every fourth Tuesday of the month, was first broadcast on August 22. Bowman along with station host Jim Cooke from Cumulus Broadcasting, have been discussing pharmacy related topics, answering callers' questions, and providing the latest information on prescription and non-prescription products.

"It is a wonderful opportunity to provide medication education to the community, while promoting Campbell University and its School of Pharmacy," said Bowman. "As an alumnus of Campbell, my Camel Pride runs deep. I will take any opportunity to promote Campbell to potential students. You never know who might be listening to the program, parents, grandparents and others, who may know a potential student for our University."

Bowman is no stranger to radio. While serving as a Pharmacy Coordinator with Kroger in Roanoke, VA, Bowman hosted a weekly show called "Ask Andy, The Kroger Radio Pharmacist" on WFIR 960AM from August 1995 until his return to Campbell in August 2000. This previous experience led to this new show.

An episode of the "Ask the Pharmacist" program usually generates calls related to over-the-counter products, herbal remedies, medications side effects and questions regarding specific disease states, like diabetes.

"The show is live, and it is sometimes challenging to know every answer on the spot," said Bowman. "I work at Walgreens in Fuquay-Varina part-time, which keeps me up to speed on community pharmacy practice. Like most pharmacists, I also actively maintain my knowledge base by reading journals and participating in continuing education programs."

The show also deals with time sensitive pharmacy and health-related topics. For example during cold and flu season the hosts will discuss preventative medicine such as flu shots.

Bowman says the show helps raise the awareness of Campbell's School of Pharmacy programs. "After 20 years, there are still people in our area of the state who are unaware of the outstanding Pharmacy program in little Buies Creek," said Bowman.

Andy Bowman takes listeners' calls on "Ask the Pharmacist." (photo by Bennett Scarborough)

calendar

March 29-30: ***Chronic Care Practice Forum meeting,*** Concord, NC.

April 14: ***Student Pharmacist Leaders Forum***, Pinehurst. NC.

April 23-25: ***Acute Care Practice Forum meeting,*** Greensboro, NC.

Save the Dates- ***Update on North Carolina Pharmacy:***

April 29, Greensboro
May 6, Charlotte
May 8, Raleigh
May 10, Asheville
May 11, Winston-Salem
May 17, Fayetteville
May 30, Greenville
June 13, Williamston
September 25, Wilson

July 13: ***North Carolina Residents Conference,*** Chapel Hill, NC.

August 10-12: ***Southeastern Pharmacy Officers Conference,*** hosted by NCAP, Washington Duke Inn, Durham.

Oct. 28-30: ***NCAP Annual Convention,*** Research Triangle Park, NC.

Jan. 17-20, 2008: ***Southeastern Girls of Pharmacy Leadership Weekend,*** Grove Park Inn, Asheville, NC.

For more information about these and other events please visit www.ncpharmacists.org

2006 Building Fund Contributors

NCAP and the Endowment Fund would like to express appreciation to those who contributed to the 2006 Building Fund campaign. Working together we met the $25,000 challenge and received a two-to-one match of $50,000 from The Pharmacy Network Foundation. If you wish to make a tax-deductible contribution to the Building Fund, please send your check to the NCAP Endowment Fund, 109 Church Street, Chapel Hill, NC 27516. A special thanks to Jack Watts who has chaired this successful campaign.

Donald L. Bennett, Albemarle, NC
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Irving Boyles, Statesville, NC
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J. Keith Caviness, New Hill, NC
Cleveland Co. Pharmaceutical Association
Contribution in Memory of Robert Kiger
Ben Collins, Greensboro, NC
Lewis N Cooper, Jr., Vass, NC
Carole Cranor, Raleigh, NC
C. Thomas Dagenhart, Jr., Gastonia, NC
Mark Davis, Lexington, NC
Thomas Peete Davis, Yanceyville, NC
Robert L. Dayvault, Jr., Kannapolis, NC
Charles Delaney, Advance, NC
Betty H. Dennis, Carrboro, NC
Steve Detter, Burlington, NC
Fred M. Eckel, Chapel Hill, NC
Stephen F. Eckel, Chapel Hill, NC
W. Keith Elmore, Wilmington, NC
Mary Ledbetter Fischer, Shallotte, NC
Gregory Fox, Winston-Salem, NC
Christine Houser Evans, Marshville, NC
Wendell Evans, Eden, NC
Julia E. Farris, Gastonia, NC
Mary Ledbetter Fischer, Shallotte, NC
J. Hugh Fletcher, Valdese, NC
Stephen Weldon Fuller, Salisbury, NC
W. S. Gardner, Burlington, NC
Mr. and Mrs. Gary Glisson, Nashville, NC
Beth Greck, Asheville, NC
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William L. Harris, Apex, NC
Henderson's Drug, Penn Yan, NY
Ruth Higgins, Black Mountain, NC
Ronald Holland, Gastonia, NC
Hollingsworth Pharmacy, Rich Square, NC
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David McSwain, Gastonia, NC
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George D. Morgan, Chapel Hill, NC
John Myhre, Garner, NC
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Franklin E. Williams, Wilmington, NC
W. H. Wilson, Raleigh, NC
Wood Pharmacy, Benson, NC

NCAP Offers Online Pharmacist Refresher Course and....

NCAP has partnered with the Connecticut Pharmacy Association to offer The Pharmacist Refresher Course, an online course designed for pharmacists who wish to return to community pharmacy practice after an absence from practice for three or more years. The course consists of three modules, all of which have been approved for ACPE credits. The first two modules are completely online and composed of weekly study segments that allow course participants to work at their own pace, on their own time. The third module consists of a three-week, 90-hour live experience in a community pharmacy. Only those who participate in all three modules will earn a Pharmacist Refresher Course Certificate from Charter Oak State College. Those taking modules One and/or Two for personal enrichment will earn ACPE credits through CPA.

A Two-Week Online Pharmacy Law/QA Course

This course will give home study law credit to any pharmacist wanting to learn about quality assurance strategies and North Carolina's pharmacy laws. This course can be used to prepare for reciprocity into North Carolina, or for those who want an update on Pharmacy Law and Quality Assurance. Students must follow a two-week course schedule. Online discussion boards and instructor monitoring and interaction keep you on track throughout the course. The course is offered the first two full weeks of every month. The registration deadline is the Thursday before each monthly course starts. This course is accredited by ACPE for 15 hours of home study law education.

For More Information visit our Web site at www.ncpharmacists.org or Call NCAP at 919-967-2237 .

2006 President's Club

The Endowment Fund and NCAP express appreciation to those who contributed to the President's Club. Tax-deductible contributions can be made on your NCAP membership renewal form or on the Web site (under Endowment Fund).

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North Carolina Pharmacist

Vol. 87, Number 2 ...applying drug knowledge to improve health Spring, 2007

You just earned a PharmD...

so now what?

Priceless Pearls for New Practitioners

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North Carolina Pharmacist

Volume 87, Number 2 Spring 2007

On the Cover

Congratulations to Wingate University's School of Pharmacy Charter Class!

Wingate University awarded diplomas to their first Pharmacy School graduating class on Saturday, May 12, 2007. The honored speaker for this historical event was Jay Campbell, Executive Director of the North Carolina Board of Pharmacy. Pictured on the cover: New Graduates Lauri Saleeby, Kevin Allen, Jeff Malone, Martha Cholewinski, Kresa Cummings and Urundi Moore.

Inside

Special Continuing Education Supplement

In order to better serve our members, NCAP will mail a special CE supplement only to members who request it. If you would like to be added to the CE mailing list please contact Teressa Reavis at teressa@ncpharmacists.org or call 919.967.2237 ext. 22

2050 and Beyond

With this issue we celebrate the infusion of 300 new pharmacists into our professional ranks. Many of them will still be guiding the profession in 2050. NCAP will be there to help them accomplish the integration. What those pharmacists will be doing may be up for debate but I believe they will still be focused on meeting patient needs. The needs will probably be similar, helping people make the best use of their medications, but the treatment approaches and the tools used may change. Instead of a "one size fits all" approach to dispensing drugs, the pharmacist may be compounding a tailored prescription for patients based on their unique genetic profile. When I started my pharmacy career allergy desensitization injection was an accepted treatment and after appropriate testing a unique desensitization formula was individually prepared for each patient. Will the genetic revolution bring compounding pharmacy back to being an important part of pharmacy practice? Many of you graduates today will know how accurate my perspective is. I hope you find your pharmacy experience as rewarding and fulfilling as I have.

This wish provides an opportunity for me to reflect again. As you begin your pharmacy practice will you be taking a job, starting a career, or entering the profession of pharmacy? A criticism often heard, especially about employee pharmacists, is that too many pharmacists see their work as a job. It pays well but they are not invested in their employer's success. They are helpful to patients but only when getting paid, and they frequently change jobs for personal reasons. Other pharmacists will see their initial job as the first rung on building a career in pharmacy. They have developed goals for themselves that will place them into an ideal role in the future and they look at each job as a learning experience that will allow them to grow into the pharmacist they plan to become. A few new pharmacy practitioners will see themselves entering the profession of pharmacy. As a professional they will recognize that they are accepting a job and are building a career, but they want to do this as they also help advance the role of the pharmacist. They see the need to do their job well as they plan and build their career, but they also accept another responsibility; they want to build their career as they help advance the profession. They want to give back to the profession of pharmacy as they use the profession to secure a satisfying job and build a career to assure personal security, happiness and hope. It is these individuals who have made pharmacy the career it is today. Those who accept that role today will be the ones responsible for shaping pharmacy's role in 2050. The pharmacy graduates of 2050 will be beholden to those of you today who are starting your career by becoming part of the profession of pharmacy. We hope you will look at NCAP as one place you can use to give something back to the profession.

Finally, let me offer one more perspective. When I graduated from pharmacy school in 1961, I heard concern that the pharmacy profession was at a crossroad. Many of you are hearing similar concerns as new practitioners today. What can we take from this observation? "The pharmacy profession is resilient" is one observation. If you meet people's needs you will have a job, a career and a profession. We have a group of dedicated pharmacists who have worked hard to address problems, help change the profession, and protect the profession from those who wanted to take advantage of pharmacy. We continue to have such dedicated pharmacists today, although we would love to have more. This means that even if you just take a pharmacy job, these professionals will be there to protect and advance pharmacy. For this reason, I believe, your future is bright.

What assures that your future is bright? I think there are two things: Developing an optimistic outlook on life and recognizing there is more than just you. For me, that's the recognition of a higher power in my life. The following email message captured the value of optimism for me recently.

"Oh sure, dreaming is the easy part! Thinking the shiny, sexy, happy thoughts. And so are the baby steps; moving with your dream. The hard part, Fred, is...well, actually, choosing words that imply you're on your way is pretty easy, too...pretending is easy...gratitude is easy...finding stuff to be happy about, easy...

Help me, Fred. I must be forgetting something. What's supposed to be the hard part?"

-The Universe

The value of a higher power in my life was captured in a meditation recently. "Be confident and never be afraid of anything or get discouraged. The Lord my God will help you do everything needed to...." (*I Chronicles 28:20B*)

My wish for each of you is that hope will always mean more than memories. **Rx**

Fred Eckel,
Executive Director

2007 calendar

Update on North Carolina Pharmacy:
May 17, Fayetteville
May 30, Greenville
June 13, Williamston
Sept. 25, Wilson

July 13: North Carolina Residents Conference, Chapel Hill, NC.

August 10-12: Southeastern Pharmacy Officers Conference, hosted by NCAP, Durham, NC.

Oct. 28-30: NCAP Annual Convention, Research Triangle Park, NC.

Jan 17-20, 2008: Southeastern Girls of Pharmacy Leadership Weekend, Grove Park Inn, Asheville, NC.

For more information about these events please visit www.ncpharmacists.org

Dear NCAP Member,

One of the perks associated with serving as NCAP president is the opportunity to travel to the schools of pharmacy and spend time with the newest members of our profession. My time with them is always so refreshing. They have so much enthusiasm for the profession and the future of pharmacy and are so eager to put their newly acquired knowledge to use by providing patient care. One of the things I try to impress upon them is how much more fulfilled they will be if they not only serve their patients, but also serve the profession. And I find that we, as pharmacists, occasionally need to be reminded of this ourselves.

During a recent visit to Campbell University School of Pharmacy, I had the opportunity to talk to students about the importance of state association involvement. It is difficult for me to talk to students about this topic without also talking to them about professionalism and leadership. Not only is the interaction with students personally fulfilling, I also use it as an opportunity to "check" myself. So, I would ask you to "check" yourself by considering the following questions:

- **Are you playing the appropriate leadership role as a pharmacist?**
  Are you simply going through the motions of being a pharmacist, or are you really making a difference?
  Do you simply do things right, or do you do the right things?

John Maxwell, in his book *Leadership 101: What Every Leader Needs to Know*, describes the importance of leadership in the following manner, which he calls the Law of the Lid.

> *"Leadership ability is the lid that determines a person's level of effectiveness. The lower an individual's ability to lead, the lower the lid on his potential. The higher the leadership, the greater the effectiveness. To reach the highest level of effectiveness, you have to raise the lid of leadership ability."*

The people we serve are depending on us to be as effective as possible; they not only expect it, they deserve it.

- **Are you doing more than talking the talk...are you walking the walk?**

Gene Lutz, past president of APhA, said it best, "Mastery of the profession makes you a professional, but professionalism is an attitude." It's about taking responsibility for your actions. Along with the responsibilities of being a pharmacist come the responsibilities of being a leader and a professional in all aspects of our work. It goes beyond our basic responsibilities of providing safe and effective pharmaceutical care. It's about making a difference in the life of a patient and advancing the profession of pharmacy.

- **How do you support and advance the profession?**

The best way I know is to be part of a professional organization. There are numerous ways to do this – some become actively involved by serving on a committee or becoming an officer, while others continue to be faithful members. Both are essential in order to grow and develop a vital organization.

Our challenge is two-fold: 1) to never stop supporting the organization even if/when we begin to take a more passive membership role within the organization; and 2) to do our part in growing the organization. The organization will never stop working on your behalf, but it cannot be as effective as its members want and need it to be without resources, both financial (dues) and human (volunteers). So, when you are reflecting on how to give back to your profession, please, if nothing else, continue to join and support our professional association. The investment in your professional future, and those who follow, will be felt for years to come and will ultimately be felt by those you serve.

Beth Williams, PharmD, BCPS
President

...applying drug knowledge to improve health

Priceless Pearls for New Practitioners

NCAP's New Practitioner Network: Addressing the Needs of New Graduates

By Abbie Crisp Williamson, PharmD, BCPS
Clinical Pharmacist, PACU/Critical Care
Duke University Medical Center
and
Jennifer P. Askew, BS, PharmD, CPP
Coordinator, Outpatient Pharmacy Services
New Hanover Health Network

What needs exist for new practitioners in North Carolina? How can NCAP meet those needs? What do you look for in a professional organization? These were all questions asked of new practitioners participating in focus groups across the state last summer. These focus groups, conducted by Beth Williams and Regina Schomberg from Wake Forest University Baptist Medical Center (WFUBMC) and Kathey Fulton from Pitt County Memorial Hospital, acted as open forums for identifying and assessing the needs of new practitioners in North Carolina. New practitioners involved in these sessions pin-pointed unique goals and important topics while voicing their desire to become more involved in NCAP. As a result of these focus groups, the Board of Directors charged us, Abbie Crisp Williamson and Jennifer Askew, two new practitioners in North Carolina, to develop and implement a formal plan for the creation of a new practitioner focus group, now named the North Carolina Association of Pharmacists New Practitioner Network (NCAP NPN).

With this charge coming in late September, we decided to hold the first meeting of this focus group at the 2006 NCAP Fall Convention. We invited new practitioners from various practice areas across the state to join us for a lunch meeting on Tuesday of the convention. Participants included: Jennifer Askew, New Hanover Health Network; Abbie Crisp Williamson, Duke University Medical Center; Debra Wobbleton Kemp, WFUBMC; Kimberly Clark, WFUBMC; Minal Patel, WFUBMC; Rachel Pendleton, WFUBMC; Sarah Ford, University of North Carolina at Chapel Hill Hospitals and Clinics; and Amanda Fuller, NC Public Health Preparedness and Response.

Excitement filled the room as we revealed for the first time the idea of this focus group. The new practitioners were energized after learning of NCAP's continued commitment to new practitioners. Throughout the meeting, individuals shared their own mission and vision for the new group. Recurrent themes of the discussion included more programming and continuing education targeted at new practitioners, mentorship opportunities, early education of pharmacy students regarding involvement in professional organizations, and a new practitioner webpage and/or listserve. In addition, we discussed administrative issues such as the designation of "new practitioner" along with structure and organization of the group. After meeting with the representative new practitioners, we drafted a proposal to be presented to the NCAP Executive Committee and the Board of Directors. We received formal approval for the formation of the NCAP NPN on November 30, 2006.

Although still in development, the current objectives of the NCAP NPN are as follows: to present a unified voice to the Board of Directors for new pharmacists on social, political and financial issues; to provide a forum for the exchange of information, professional development strategies, and innovative ideas among new pharmacists; to promote the future of pharmacy and enhance patient care by fostering the growth and development of new practitioners in North Carolina; to anticipate future information and professional development needs for new pharmacy practitioners; and to strengthen

relationships among pharmacy students, new practitioners, seasoned pharmacy practitioners and other health care professionals.

Since January 2007, members of the focus group, consisting of the attendees of the Fall Convention focus group along with Larry Buie (UNC Hospitals and Clinics), have met monthly via conference calls supported by NCAP. With the NCAP NPN in its early developmental stages, the conference calls have focused mostly on administrative items such as drafting the NCAP NPN Operational Plan, which will consist of both the Bylaws and Strategic Plan, and membership/recruitment. On a more exciting note, the group is creating an NCAP NPN webpage and exploring the possibility of a listserve and newsletter. A brief update on each project is listed below.

• **Development of the NCAP NPN Operational Plan (Bylaws and Strategic Plan)-** Based on the NCAP Bylaws, we drafted a first version of the Bylaws and discussed revisions at the March conference call. The Bylaws will serve as the governing document of the NCAP NPN and address such topics as new practitioner designation, executive committee/officer appointment and responsibilities, and general operating provisions. Writing of the Strategic Plan, including the group's mission and vision, is the next project on the agenda. Unlike the Bylaws, the Strategic Plan will change more frequently to meet the dynamic goals of the NCAP NPN. The Operational Plan will be approved and implemented by January 2008.

• **Membership/Recruitment-** The group is considering both new practitioner designation and the means of membership recruitment. We are determining the optimal number of years to consider North Carolina pharmacists as "new practitioners" once they graduate from schools of pharmacy. Once this decision is made, we will develop a recruitment plan for 2008.

• **Creation of a NCAP NPN Webpage-** We are working closely with Sally Slusher, NCAP's Director of Communication, to develop the NCAP NPN webpage on the NCAP website. The group approved the webpage outline during the March conference call and is arranging for it to be posted on the NCAP website by this summer. We designed the webpage to serve as a valuable resource for new practitioners by including sections for hot topics, legal and public affairs, finance and investing, and links to other pharmacy organizations' new practitioner sites. The webpage will also contain the NCAP NPN Operational Plan, mission and vision, meeting minutes, and contact information for the current focus group members.

• **Other Projects-** We are investigating the possibility of creating an NCAP NPN listserve and newsletter and exploring new and innovative ways to "virtually" communicate.

With all of these projects on our plate, we are thankful to have such a dedicated group of enthusiastic new practitioners to help us lay the foundation for this important network. When asked "Why do you participate in the NCAP NPN?" members of the NCAP NPN responded:

"I think that we are the future of the profession, and we need to get involved now to learn from more seasoned pharmacists and begin to help steer the course for what is to come. However, I found it difficult to network locally with other new practitioners once I was done with my residency, and most of my past volunteer experience has been with national associations. I think we are so fortunate that NCAP has shown an interest in cultivating and motivating those of us who are new to the profession. Now I can network, stay active in pharmacy associations, and make a difference on a local level - much closer to home!" *- Jennifer Askew*

"I chose to become involved with the NCAP NPN because it provides a great opportunity for new practitioners to network and form professional relationships while careers are still being established. At the same time, the network will allow for the development of programming specifically designed for new practitioners to be delivered by new practitioners. This will foster professional development while delivering quality educational sessions." *- Larry Buie*

"I wanted to participate because I work in a non-traditional pharmacy setting and NCAP NPN keeps me in touch with other new practitioners. It also gives me a network of pharmacists to contact with questions or for their thoughts and experience."

- Amanda Fuller

The NCAP NPN is dedicated to identifying and addressing the needs of new practitioners. The future of the NCAP NPN and pharmacy as a whole in North Carolina will not only be dictated by us, the current members of the NCAP NPN, but by all new practitioners from around the state. It is wonderful to know that NCAP is serious in its commitment to foster the growth and development of pharmacists new to the profession. By creating the NCAP NPN, NCAP has demonstrated that it values new practitioners as the future of pharmacy and is willing to invest time and resources in addressing their unique needs. The North Carolina Association of Pharmacists truly wants to create a home for new practitioners. The next time you wonder, "What is NCAP doing for me?" we encourage you to think of the NCAP NPN as an investment that NCAP is making for the future of the profession.

Who would have thought I'd own my own pharmacy!

By Ruth H. Higgins. RPh., CDM
Pharmacist Owner
Medicap Pharmacy
Black Mountain, NC

Who would have ever thought 30 years ago when I graduated from Pharmacy School that one day I would own my own pharmacy! At the time, my dad was eager to offer me rental space beside his barber shop in our small town back home in Hudson, NC. I ran as fast as I could to a chain store job in Asheville. I thought that I didn't know anything about running a business. "I '*just*' want to be a pharmacist," I said.

I had no idea of the opportunities that pharmacy presented, or of the multitude of roles that being a pharmacist could offer.

There have been so many changes in these 30 years. The role of female pharmacists has evolved. Huge salary changes have occurred. What was at one time largely retail or hospital is now limited only by the imagination of each practitioner's concept of pharmacy in today's health care arena. "Lick and stick" has become disease state management and clinical specialization. Pharmacists have had to learn to adapt to changes in the marketplace as much as any profession. The good news is that this change has brought with it many different career paths that encourage personal growth while enhancing our roles in the health care community.

My career path has taken several turns. After working for a couple of different chains and time spent in a county health department pharmacy (so that I could have that 8 to 5 job and find child care), I discovered that I was still seeking a vehicle to do pharmacy "my way." I had done relief work at several different independent pharmacies and came to appreciate the freedoms associated with having your own practice. I saw that if I wanted to come out from behind that counter and realize my goal of becoming responsible in a personal way to those patients who put their faith in me, I needed to open my own pharmacy.

At that point, (after being out of the academic arena for seventeen years) I understood the need to involve myself in more educational development. Luckily, this was at the beginning of the Asheville Project in our community. By becoming a part of that first group of community pharmacists who set out to prove that we could make a difference through education and lifestyle management, I have been able to satisfy not only career goals but personal goals as well. Since then I have become credentialed in diabetes and asthma, and locally certified in hyperlipidemia and hypertension. We are very fortunate in North Carolina that we have access to such high quality Area Health Education Centers. They support all areas of learning and challenge all of us to stay up to date on current trends and practices. Involvement with the three schools of pharmacy in our state as a preceptor over the past ten years has challenged me to stay engaged and embrace change.

My success as an independent pharmacist over the last twelve years has come with the support of a loving husband (that I talked out of pharmacy school 30 years ago when he was a chemistry major at UNC) and a family that has pitched in at every corner to help!

I have also had wonderful peer support from many of my friends in the professional community. Before the days of computers, the one thing UNC taught me is that you will never know all the answers, but by developing professional relationships, you can know your sources and know where to go to get help. I have always supported the team concept. My Carolina alumni family has helped me stay involved with one of the best schools of pharmacy anywhere. NCAP and its leaders over the years has been a force that has not only facilitated the community of pharmacy in our state, but also has been visionary in the leadership of pharmacy across the nation. Being a franchise pharmacist and meeting pharmacists from across the nation, I have grown to really appreciate the leadership of North Carolina people like David Work, Fred Eckel, Dan Garrett, and Steve Caiola. These are but a few of the leaders who have blessed our community through their insight, inspiration, and hard work.

What made my choice of independent pharmacy so special to me over the years? My patients. Each and every person entering my pharmacy has a medical need and it is my challenge as a pharmacist to do the best I can to meet that need. The uniqueness of independent ownership is that many days I feel like an octopus managing dispensing and drug interactions, business decisions, diabetic counseling, compounding, and simply trying to be there for my patients. When you add to that the challenges that today's third-party environment bring (arguing with third-party payers as a patient advocate and explaining Medicare Part D), it is always a challenge to find enough time to fit in everything. You do it, though, because ***you make a difference if you remember to always put the patient first.***

Pharmacy may be a "career of opportunity," but without the dedication of self to service, it is an opportunity that falls short of great possibilities. I have begun to realize that being a pharmacist today may just be like the amoeba. We begin as one person, one pharmacist, one cell – yet we can make a difference because each effort has potential to multiply its effects a thousand fold if we make every encounter count for good in our patients' best interest.

The Hospital Pharmacy Director, Yogi Berra and You

It's April, there's another blizzard in Boone, and somewhere where it's warmer (probably not in Cleveland), they're playing baseball.

By Stephen R. Novak, RPh, MPA, FASHP
Director, Pharmacy Services
Watauga Medical Center
Boone, NC

I have just recently accepted an offer as a pharmacy director at a hospital in southwestern North Carolina. My wife and I spent the weekend cleaning the basement and getting ready to put the house on the market. We have decided it was time to simplify, downsize to a smaller house, and dispose of most of extra "stuff" we have accumulated. Over the years, our basement had become a repository of discarded possessions and collections of a family of five. As we sorted through each box, we made the decision to pitch, keep, donate or label for passing down to our three sons.

We sorted through many boxes containing the boys' sports equipment, trophies and memorabilia. There were boxes of loose baseball cards along with a variety of albums. I sat for a minute and flipped through them. Most of the cards were from the 80's and 90's, but there were a few 60's from the Detroit Tigers and their longtime rival, the New York Yankees. I began to reminisce about my youth. My home team Tigers had a strong line-up - Al Kaline, Norm Cash and Rocky Colavito, but the Yankees had a roster of superstars – Mickey Mantle, Roger Maris, Whitey Ford and Yogi Berra. Berra, the catcher, won several World Series with the Yankees. He went on to become the manager and won pennants for both the Yankees and Mets, was voted into the Baseball Hall of Fame in 1972 and retired in 1992. Yogi's transition from a catcher (specialist) to a generalist (coach/manager) can be analogous to a pharmacist (drug specialist) pursuing a career as a hospital pharmacy director (generalist/coach/manager). Yogi is also famous, or infamous, for his perspectives on life and is one of the most frequently quoted sports figures. His malapropisms, called Yogi-isms, are applicable to pharmacists considering hospital pharmacy management as a career.

"If you come to a fork in the road, take it."

The average American changes jobs 10 times and switches careers three times over the course of a lifetime. Throughout my career, I've worked as a pharmacist in hospital, retail and consultant pharmacies and as a pharmacy director in community care (HMO) and hospital pharmacies. By making a job change when the opportunity is presented (the fork in the road), new experiences and opportunities for growth have been made available to me.

My decision to pursue a Masters Degree in Public Administration in the early 80's led me from a hospital environment as a staff pharmacist to my first pharmacy management position in an HMO. By focusing on a health care concentration in graduate school, I was knowledgeable about HMO's and the vital role of patient education in

maintaining wellness. In my first pharmacy management role, I was able to design a pharmacy service where the work flow maximized the pharmacist/patient interaction. Technicians processed the prescription and the pharmacist counseled the patients in booths specifically designed for privacy. Pharmacists also co-taught patient classes in hypertension, asthma and allergies, diabetes and arthritis. It was a great opportunity to design and provide appropriate pharmacy care and help patients make the best use of their medicines. By taking the step to pursue a graduate education (MPA degree), I was afforded the opportunity I may not have had without it.

The HMO experience in pharmacy management also provided the experience and opportunity (fork in the road) to relocate from the economically depressed state of Michigan to a hospital pharmacy director position in a thriving North Carolina. Although I didn't realize it at the time, the move to North Carolina really opened new doors and opportunities for my pharmacy career.

"You can observe a lot just by watching."

The collegial environment of acute care pharmacy practice in North Carolina has been fantastic for me. North Carolina has a rich history of professional contributions and leadership at the national pharmacy level. I've learned a great deal from my colleagues through participation in the old NCSHP and the Acute Care Practice Forum of NCAP. Opportunities for participation in local, regional (AHEC), state (NCAP) and national (ASHP) pharmacy organizations provide the network to communicate and learn how to resolve pharmacy practice problems. I keep in regular communication with colleagues on the internet, over the phone, at pharmacy meetings and CE. I've found that it's easier to communicate electronically once you've made the personal contact at NCAP and other meetings. I've been in pharmacy management for 28 years and it's never been as difficult or as rewarding to be a pharmacy director as it is now. The financial, technological, and regulatory pressures, along with the growing complexity and sophistication of medication therapy, demand more attention and creativity from pharmacy leadership than ever before. The growing demand for services with a shrinking resource base is difficult and provides challenges that can be overwhelming to individual directors.

The connectivity available through NCAP and ASHP is also based on participation and contributions made to the professional organizations. By making the decision to actively participate, individuals contribute a new piece of the puzzle that gives everyone a clearer picture of what the successful pharmacy picture looks like. To "observe a lot by watching" is predicated by participation in the first place.

"I wish I had an answer to that because I'm tired of answering that question."

In making the decision to be a pharmacy director, you're making the decision to become a pharmacy generalist. As a pharmacist, your focus and education have been on becoming a medication specialist. However, with the broader demands of pharmacy management, you tend to know a little less about much more – recruitment,

personnel, finances, hospital politics, legislation and regulations affecting pharmacy, etc. There's an assumption from others within your department that you will have immediate answers for everything. Although at first, it may seem a daunting situation, it is one that can be remedied by combining the unique strengths and skills of your staff. You become a more effective leader by developing and involving the expertise of others. To do so, you have to have an eye for talent and provide the opportunity and environment for learning. The development of employees and students has been the most rewarding aspect of my pharmacy management career. I've been successful through contributions of talented and caring individuals who have grown in their jobs. Their success is my success.

And one more "Yogi-ism...

"You've got to be careful if you don't know where you're going, because you might not get there."

To be successful as a pharmacy director, you need a vision of what/where you want your pharmacy practice to be. Once determined, communication of that vision to others is essential. You do this by constantly assessing your strengths and weaknesses. Like a baseball manager, you provide coaching and reinforcement. Where you have a void you hire a free agent or call up a promising rookie from the minor leagues. During the game you make constant adjustments to new situations. Do these things and you'll have a winning record. Do these things well as Yogi Berra did and maybe you'll win a championship. Let's "PLAY BALL!!"

Long-term Care Leadership

By Cecil M. Davis, PharmD, CGP, RPh
Director of Pharmacy
Holladay Healthcare Pharmacy

After graduation from Campbell University School of Pharmacy I spent time in both an independent community retail store and a small rural hospital. However, when I moved into long-term care pharmacy I realized that I wanted to make a career in this area. I began as an entry-level pharmacy consultant for a national company in 1992. This company had very strong mentors and a formal education program for its clinical staff. It also had a great program to identify untreated conditions and exceptional therapeutic interchange program. In addition, some of the consultant's interventions were processed as community based clinical trials. I had the opportunity to work in very progressive facilities that pursued quality. It was during this time that I learned the impact consultants could make in a healthcare system. Since I lived in Asheville at the time, the company licensed me in Tennessee, Virginia and South Carolina. Being licensed in the surrounding states is important with the larger companies since they typically service across state lines. In addition, it gives you a greater geographic area to find a branch where you can be involved in management. I had asked one of the regional

vice-presidents how he made the move into management. He told me that he started in a small branch pharmacy in order to learn the operations part of long-term care. Being a part of a large company typically means being willing to relocate in order to manage a smaller branch. Since I was not willing to relocate I continued to consult. The pharmacists that I worked with were very involved with the American Society of Consultant Pharmacists (ASCP) North Carolina Chapter and encouraged my attendance at the yearly Carolina Conference. My association with ASCP started my first year as a consultant. Our company encouraged attendance at each Carolina Conference. Since the Carolina Conference was primarily attended by members of the North Carolina ASCP chapter, it allowed me the opportunity to meet many of the leaders in the long-term care profession. Soon, I was able to begin working with committees for the ASCP chapter. NCAP and subsequently the Chronic Care Practice Forum, provided excellent networking opportunities and a wealth of knowledge to improve my practice. In addition, NCAP keeps me aware of legislative efforts that may affect my practice.

In 1999 when I began working with a smaller company as a consultant, I had the opportunity to manage the consulting. As we hired more consultants I became aware of the need for advanced credentialing for myself and obtained my CGP (Certified Geriatric Pharmacist). I also became involved with board work with North Carolina Assisted Living Association (NCALA) and NCAP. In addition, I became a facility level trainer in Virginia. Working for this smaller company gave me the opportunity to become the director of clinical services. It was during this time that I began to express an interest again in the Quality Assurance and management side. After nine years of consulting and being involved with the management of consulting, I made the move to pharmacy manager.

New graduates who hope to manage in long-term care pharmacy need to become involved now with long-term care. Attend the Chronic Care Practice Forum meetings. Become a member of ASCP. Shadow a consultant. During pharmacy school there is much talk concerning "networking." However, "networking" is typically lost on students. Learn to network with people in the industry. Do not hesitate to talk with managers and consultants at NCAP and ASCP meetings. The more people who know you, the more likely you are to land a job in long-term care. If your school has a rotation at a long-term care site, attend that rotation. One of the best hires we have made came from our involvement with student rotations. During the summer work as a technician in a long-term care pharmacy. Your experience as a technician will give you a greater understanding of how the pharmacy operates when you are able to move into management. You will need to spend your time as a staff or consultant pharmacist prior to being effective as a manager. I have had one manager colleague that had each consultant spend time both inside the pharmacy and outside each week. This gave the consultant a better understanding of problems they may have noticed in the buildings. When you are looking for that first job do not be concerned about the size of the long-term care company. Large corporations typically have much to offer in training and mentorship. They may also have formal management tracks. I would caution that you will probably need to be willing to relocate to effectively utilize a management track. Smaller operations also have much to offer in that you can be involved in all aspects of the business.

Once you move into management there are many benefits of being a Director of Pharmacy. You have the chance to shape your practice according to your vision for pharmacy. I work for a company that has allowed me to implement technology to improve the way we dispense medications. You can develop your leadership style in how you interact with your staff and clients. Working with pharmacy and technician students is very rewarding since you can foster a love of the profession. The responsibility for the success or failure of the branch resides with how you manage. A definite advantage is being able to implement your ideas and see them play out in the market. That said, the following quote reflects how management should work. C. William Pollard (former CEO of Servicemaster) wrote in *The Soul of the Firm* –

> "The truth of what we say is told by what we do. This standard of truth requires leaders to be role models and to provide an open environment in which their decisions and actions can be examined. It also required leaders to admit when they are wrong. This in turn encourages an environment where people report on what has occurred or is anticipated, not on what will make them look good or will allow them to avoid confronting a problem. We should always test our decisions and actions with the expectation of full disclosure to those affected by them."

Long-term care pharmacy is at a definite cross-roads. Margins continue to shrink while facilities are demanding higher levels of services. Technology provides us with the ability to scan for errors. Document handling systems will begin to redefine when and where orders are processed. Companies are moving into North Carolina that will offer greater flexibility in how data entry and pharmacists are utilized. The issue of tech-check-tech is being tested in the state and has the possibility of having a tremendous impact in long-term care. We need leaders that can see the opportunities of the future and bring them together in a way that benefits our residents and preserves our profession for the future.

NCAP Membership Opens the Door to Opportunities

By Brenden O'Hara, RPh
Pharmacy Manager
Walgreens, Cary, NC

Currently, I am a Pharmacy Manager with Walgreens in Cary, but my career in pharmacy began in 1990 at Fay's Drugs in Binghamton, New York. During my tenure at Fay's, I learned several different aspects of community pharmacy operations. With Fay's I held positions from stock clerk to intern and ultimately, pharmacist. Working my way up the ladder allowed me to learn marketing, inventory management, procurement, accounting and customer service in addition to the fundamentals of practicing pharmacy in a community environment. Throughout my internship, I was always very eager to do extra. My dedication and desire to learn was evident, and I was afforded unique opportunities including training new hire pharmacists, scheduling pharmacists, doing pharmacy inventories, training staff on a new computer system and representing the company in several health fairs. In the blink of an eye, my internship was complete and it was time to put what I had learned into practice.

I graduated from Albany College of Pharmacy in 1997. Upon graduation I took a job with Eckerd Drugs, who had just purchased Fay's Drugs. With Eckerd, I transferred to an area of need and was

quickly named the supervising pharmacist in a busy store in Ithaca, New York. The following year, I relocated to Raleigh, North Carolina. In North Carolina, I traveled to areas of need, assisted my District Manager with various tasks, did scheduling and assisted with store staffing. Basically, I made it my duty to make my District Manager's (DM) job easier. All this time I was eagerly learning the ins and outs of doing his job. Within one year of relocating I was promoted to District Pharmacy Manager for Eckerd Drugs in Durham. I served Eckerd in this capacity for five years until I switched teams and came to Walgreens. Although I am not a District Manager with Walgreens, I am managing a new store in Cary and continue to satisfy my desire to learn by remaining active with professional activities. In addition to precepting students from Purdue, Ohio State, UNC and Campbell Schools of Pharmacy, I am working with Walgreens to develop an immunization program for the Raleigh West District. I remain active with NCAP (on various task forces and the Community Care Practice Forum) and serve on the North Carolina Pharmacist Recovery Network (NCPRN) Board of Directors. I am fortunate to have these opportunities to contribute to our profession and have learned that a "leader" is who one is and what one does, rather than a title one holds. For me, leadership in community pharmacy has held many faces from stock boy to cashier to pharmacist.

Some benefits of being a leader in a community pharmacy include being on the cusp of new developments in the profession. Community pharmacy leaders are often tasked with implementing strategies to remain competitive as both employers of choice and profit generating enterprises. Every pharmacy is competing and trying to outdo the next one. Leaders are making decisions and changes every day. The ideas you have to improve work environment and help retain staff, for example, are rolled out to your staff and possibly to the company. Leaders are the "company" to your patients, employees and colleagues. Likewise, you are the employee representative to the CEO and Vice Presidents. As a leader, what you do reflects on you as a person and the company. As the most accessible healthcare provider, community pharmacy leaders carry a tremendous burden to make sound decisions, propel the profession forward and continue to represent pharmacy well to the world and maintain that number one trusted title.

My first exposure to NCAP was during a leadership forum that I attended with my District Manager shortly after moving to North Carolina. This meeting inspired me to become involved. I knew I had to be more than a passive member, so I inquired as to where my knowledge would be beneficial. It was suggested that the Membership and Marketing Council needed some help so I became involved in that, becoming Vice Chair and ultimately the Chair. From there I became involved in the Ambulatory Care Practice Forum (we ultimately changed the name to the Community Care Practice Forum because we felt it better reflected the group we wanted to represent). My membership in NCAP has allowed me to become involved in the profession at another level, whether it be a member of NCAP, or Chair of its Community Care Practice Forum, a member of the by-laws committee, a Delegate to APhA, or a member of the NCPRN Board of Directors. All of these doors have been opened by my involvement in NCAP. Each of these experiences have helped me grow, meet new people and best of all LEARN!! Not being a native to North Carolina may appear to be a disadvantage, but it also gives you a fresh perspective on the profession. I would challenge you to compare opportunities in North Carolina to other states. We have many professional abilities afforded to us that we take for granted. Almost every one of those opportunities is a direct result of the efforts of NCAP. In addition, my involvement in NCAP has opened the door to many new friendships and opportunities.

I bring to my current position and every position I take, a love for the profession. I want to share that with others. I want to get others excited about what they do, whether it be to ignite their flame about joining an association or reignite a desire to become involved in something bigger. I try to make work fun.

This issue of *North Carolina Pharmacist* is for my new colleagues. For you, I will leave these pearls. Do your job for you! Don't do it for the money or the prestige. I promise you someone will come along and try to offer you more money, or something better. Do your job well because it reflects who you are. Be the person your supervisors, your subordinates and your colleagues look to for leadership. Be the pharmacist and person they aspire to be. Leave your mark on the profession by accepting the challenge to be a leader. You need to challenge yourself every day so you don't become complacent. Work for this challenge. Your satisfaction will be your reward! **Rx**

Allergy Defense Systems

Consider the following questions as they apply to your practice:

- Whose job is it to interview, document, verify and use allergy information?
- Where are allergies documented in the record and in how many different places?
- Is the reaction/outcome documented along with the drug name?
- How do you document drug intolerances and contraindications?
- How does your IT system support the "allergy defense" process?
- Does your system detect and alert for "cross allergies"?
- Does your system document the level of significance?
- If you have electronic alerts, are each of these features "turned on"?

by Jahn M. Kessler, PharmD, BCPS

Perhaps, one of the most fundamental purposes for screening new drug orders is to keep patients from receiving drugs they should not be exposed to. This is a therapeutic principle taught to students in every healthcare discipline. No practitioner wants to be responsible for giving a drug that is likely to cause a problem. Large amounts of energy and resources are expended to prevent these events from happening. Why is it then, patients continue to receive drugs when they have a known allergy or intolerance? Part of the answer is that the *allergy defense system* in healthcare is a patchwork of smaller processes with very little accountability for accuracy, completeness or cross-discipline functionality. Most often, these workflows operate within professional silos, not supporting the needs of the team. In short, the multidisciplinary team isn't working together and the game plan is flawed.

Several key weaknesses or failures include: (1) the term itself – *allergy*. When taking the medication history, practitioners frequently ask the patient about past "*allergies*." This interview approach can fail to identify important adverse reactions and intolerances, especially when the patient interprets *allergy* to mean rash. The medication history should solicit information about significant drug reactions regardless of mechanism; (2) flaws in the way that *allergies* are recorded (see tables below); (3) allergies are reported during the medication history; however more than one author has written that inexplicably, these *allergies* are not documented in medical records; and (4) lack of standardization in the use of *allergy alert* arm bands, chart tape, door/bedside stickers, and similar devices used to alert staff.

Flaws common to paper and electronic systems include:

- Reaction not listed
- Significance not listed
- Reaction date not listed
- Inaccurate information difficult to delete or correct
- Person verifying the allergy not recorded
- Source of the allergy information not listed
- Food-drug reactions not listed
- Drugs administered/dispensed before pharmacy verifies order
- Terminology not clear nor agreed upon by clinical staff
- Failure to require allergy data input before prescribing or dispensing
- Failure to "reverse check" drug list when new allergies are documented
- Staff "work-arounds" such as entering "no allergy data" when, in fact, the allergy history has not been taken

Flaws in paper-based documentation systems include:

- Allergy data not available at the point-of-care
- Allergy data often "buried" in paper and difficult to retrieve
- Allergy data appear on multiple forms and rarely reconciled

Flaws in electronic-based documentation systems include:

- Free text allergy fields do not cross-check allergies against new orders
- Drop-down lists lack new drug names, OTC drugs and herbals
- Allergies not stored and retrieved from a central data repository
- Allergies not displayed on future encounters and must be re-entered into the new profile each time
- Allergies are "carried forward" and displayed on future encounters but not verified for accuracy
- Allergies not intercepted at the time of prescriber order entry (CPOE)
- Alerts for minor reactions display the same as alerts for significant reactions
- Accidentally overriding alerts and not being able to reverse the process
- Accidentally "entering" past the alert display when computer key-strokes are faster than computer processing speed
- Severe allergy alerts (e.g. anaphylaxis) do not result a "hard stop" for the order

Other system failures include:

- Lack of competency-based training on taking and recording an "allergy" history.
- Clinicians are desensitized to frequent allergy alerts
- Clinicians falsely assume some allergies are simple intolerances such as dyspepsia
- Disagreements about clinical significance of cross-reactions – overriding alerts
- Failure to recognize or act on potential cross-reaction alerts
- Failure to verify allergy "orders" when they are entered (a process similar to verifying prescription orders when they are entered)
- Allergy data not transferred during acute care and ambulatory care transitions
- Failure to periodically review "overrides" and the reported justifications

Regardless of the type of system – paper or electronic - accurate and complete *allergy* entries are as important as the entry and verification of a new prescription. Similar to the "rights" of STARTING a medication; it might be helpful to think about a similar set of "rights" for an *allergy* order to effectively STOP a medication from reaching the patient. (e.g. the "right" drug, reaction, level of significance, date, and person documenting the allergy). Perhaps, anything less, should be considered an incomplete "order" that cannot be implemented until verified by a pharmacist. **Rx**

About the Author...

John M. Kessler, PharmD, BCPS is President and Chief Clinical Officer of SecondStory Health, L.L.C. and Chair of the NCAP Acute Care Practice Forum. *He wishes to gratefully acknowledge Mr. Bill Harris, Supervisor-Medication Safety, Duke University Hospital, for his critical review of this article.*

2007 Acute Care Practice Forum Meeting

NCAP's Acute Care Practice Forum held their annual meeting April 23-25 at the Sheraton Four Seasons in Greensboro.

John Kessler, Chair of the Acute Care Practice Forum, presented the 2007 Acute Care Pharmacist of the Year award to Steve Caiola.

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NCAP Election & Award Nominations Sought

NCAP Election

Deadline for nominations is July 2, 2007

NCAP Members are invited to make nominations or submit their interest in being considered for the 2007 election ballots. Nominations must be in writing (includes email). NCAP will elect a 2008 President-Elect (to serve as President in 2009, 3-year term) and two At-large Board members (3-year terms). Send nominations to NCAP Nominations Committee, 109 Church Street, Chapel Hill, NC 27516 (FAX 919-968-9430 or email linda@ncpharmacists.org).

Acute Care Practice Forum: The Practice Forum will elect a Chair-Elect (3-year term), two Executive Committee members (3-year terms) and one Delegate to ASHP (3-year term). Members of the Practice Forum may submit their nominations to John Kessler, Chair of the Acute Care Practice Forum (jkessler@secondstoryhealth.com).

Chronic Care Practice Forum: The Practice Forum will elect a Chair-Elect (3-year term) and three Executive Committee Members (3-year terms). Members of the Practice Forum may submit their nominations to Athena Smithwick, Chair of the Chronic Care Practice Forum (athenalocklear@aol.com).

Community Care Practice Forum: The Practice Forum will elect a Chair-Elect (3-year term) and two Executive Committee members (3-year terms). Members of the Practice Forum may submit their nominations to Lori Brown, Chair of the Community Care Practice Forum (lbrown@kerrdrug.com).

Awards

Deadline for Nominations is July 2, 2007.

It is a privilege for the North Carolina Association of Pharmacists to recognize excellence within the profession. NCAP will present the Awards at the Convention, October 28-30 in Research Triangle Park, NC. Nominations must be in writing (includes email) and include biographical data on the nominee for review by the Awards Committee. Submit to Awards Committee, NCAP, 109 Church Street, Chapel Hill, NC 27516 (FAX 919-968-9430 or email linda@ncpharmacists.org). The Board of Directors invites NCAP members to make nominations for the following awards.

Don Blanton Award: Presented to the pharmacist who has contributed most to the advancement of pharmacy in North Carolina during the past year. This award was established by Charles Blanton in memory of his father, Don Blanton, who served the North Carolina Pharmaceutical Association as President 1957-58.

Elan Innovative Pharmacy Practice Award: Presented to a pharmacist practicing in North Carolina who has demonstrated Innovative Pharmacy Practice resulting in improved patient care.

Pharmacists Mutual Distinguished Young Pharmacist Award: Criteria for this award are: (1) Entry degree in pharmacy received less than 10 years ago (1997 or later graduation date); (2) Licensed to practice pharmacy in NC; (3) Actively practices retail, institutional, managed care or consulting pharmacy; (4) Participates in national pharmacy associations, professional programs, state association activities and/or community service.

Wyeth Bowl of Hygeia Award: Criteria for this award are: (1) Licensed to practice pharmacy in NC; (2) Has not previously received the Award; (3) Is not currently serving nor has he/she served within the immediate past two years on its awards committee or as an officer of the Association in other than an ex officio capacity; (4) Has compiled an outstanding record of community service, which, apart from his/her specific identification as a pharmacist, reflects well on the profession.

Continuing Excellence Program

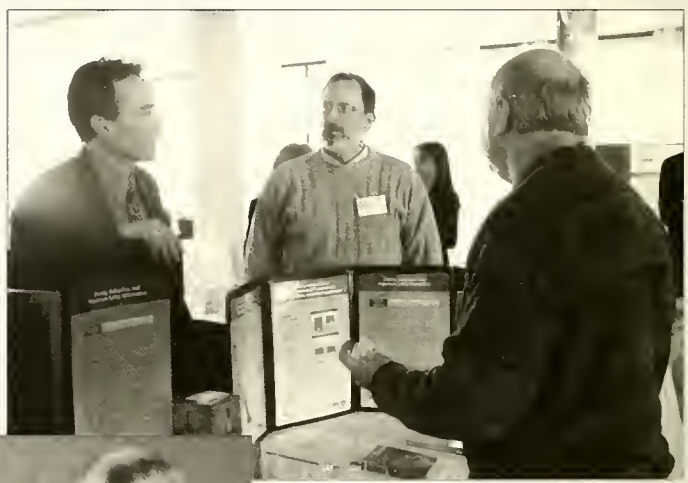
Deadline for applications is Feb. 1, 2008.

The purpose of the Continuing Excellence Program is to recognize individuals who have distinguished themselves through sustained service to the profession and the public and to promote an awareness of NCAP and the profession of Pharmacy among the public and other health professions. Program Criteria and application form are available on the NCAP website (www.ncpharmacists.org) or you may contact Linda Goswick at NCAP (919-967-2237 / linda@ncpharmacists.org). Award recipients will be recognized at the 2008 Practice Forum Meetings.

2007 Community Care Practice Forum Meeting

Pharmacy professionals gathered February 18-19 at the Sheraton in Chapel Hill for NCAP's Community Care Practice Forum Meeting. On February 17 a Pharmacy-Based Immunization Delivery Certificate Program was conducted for those wishing to provide immunization services to their patients. To kick off the conference NMA/NASPA held a Student Pharmacist Self-Care Championship; "Who Knows the Most About OTC Drugs?" Teams of students form North Carolina's three pharmacy schools competed and Campbell University took first place.

Lori Brown, PharmD (right) presented the 2007 Community Care Pharmacist of the Year award to Beverly Lingerfeldt, RPh for her outstanding accomplishments in community pharmacy.



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Professional Immunity?

Many healthcare professionals believe that they are safe from the disease of substance dependence (the new buzz words for drug addiction).

The fact is that intellect and education are of little protection against this devastating disease. Addiction will affect 8 to 10% of the U.S. population. Many addiction professionals believe that the percentage is significantly higher for healthcare professionals. James W. West, MD, Medical Director Emeritus of Betty Ford Center, has treated physicians and other healthcare professionals for addictions for over 60 years. He believes that the occurrence of the disease in this population is 15 to 20%. Opinions on the causation of this pattern in pharmacists, physicians, dentists, nurses and others varies greatly. Almost certainly stress, overwork, and perfectionism are part of the story.

Should you wish to know more, or know of someone who may need help, call NC Pharmacist Recovery Network at 919-545-8800 or check out their website at www.ncprn.org.

NCAP's First Annual Chronic Care Practice Forum Meeting

On March 29-30 history was made when NCAP held the first annual Chronic Care Practice Forum Meeting at Embassy Suites Golf Resort & Spa in Charlotte-Concord, NC. (Photos courtsey of Campbell University pharmacy student Lindsay Sampson)

Valerie Brooks, PharmD (left) receives the Chronic Care Pharmacist of the Year Award from Athena Locklear Smithwick, Chair of the Chronic Care Practice Forum.

Judy Jones, PharmD (right) presents the first NCAP Excellence in Geriatrics award, The Dale Jones Memorial Award, to Kaye Vass, PharmD.

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Travel With NCAP

NCAP and Collette Vacations will co-sponsor the following trips in 2007-2008.

California New Year's Getaway – December 29, 2007. Featuring the Tournament of Roses Parade and the Crystal Cathedral with optional 2-night Las Vegas extension.

Prague/Budapest - April 2008

Italy - September 2008

For information on these trips, please contact Linda Goswick at NCAP (linda@ncpharmacists / 919-967-2237). If you are interested in travel with a group to other sites in the US and abroad, contact NCAP and we will be happy to assist.

Dividends Returned

Pharmacists Mutual Insurance Company, the leader in serving the insurance needs of pharmacists, is pleased to announce the distribution of dividend checks for 2006. Over 14,000 checks, totaling $4.1 million were recently mailed to the mutual company's commercial policyholders. This distribution represents a return to policyholders of a significant percentage of the company's 2006 underwriting profit. Pharmacists Mutual has returned dividends to policyholders in each of its 98 years.

Pharmacists Mutual Honors Stoll

Ronald Stoll, LUTCF, North Carolina Field Representative, was presented with the "Commitment to Excellence" award for the third year in a row at Pharmacists Mutual's Annual Sales and Marketing Meeting held in February. Ron joined Pharmacists Mutual as a field representative in 1996.

NCAP Offers Online Pharmacist Refresher Course and....

NCAP has partnered with the Connecticut Pharmacy Association to offer The Pharmacist Refresher Course, an online course designed for pharmacists who wish to return to community pharmacy practice after an absence from practice for three or more years. The course consists of three modules, all of which have been approved for ACPE credits. The first two modules are completely online and composed of weekly study segments that allow course participants to work at their own pace, on their own time. The third module consists of a three-week, 90-hour live experience in a community pharmacy. Only those who participate in all three modules will earn a Pharmacist Refresher Course Certificate from Charter Oak State College. Those taking modules One and/or Two for personal enrichment will earn ACPE credits through CPA.

A Two-Week Online Pharmacy Law/QA Course

This course will give home study law credit to any pharmacist wanting to learn about quality assurance strategies and North Carolina's pharmacy laws. This course can be used to prepare for reciprocity into North Carolina, or for those who want an update on Pharmacy Law and Quality Assurance. Students must follow a two-week course schedule. Online discussion boards and instructor monitoring and interaction keep you on track throughout the course. The course is offered the first two full weeks of every month. The registration deadline is the Thursday before each monthly course starts. This course is accredited by ACPE for 15 hours of home study law education.

For More Information visit our Web site at www.ncpharmacists.org or Call NCAP at 919-967-2237.

Pharmacy Time Capsules

1982—Twenty-five years ago:
- Board of Pharmaceutical Specialties begins certification in Nuclear Pharmacy

1957—Fifty years ago:
- Orinase marketed
- Influenza pandemic of 1957. There were seven U.S. manufacturers of vaccine—Eli Lilly, Pitman-Moore, Lederle, National Drug Company, MSD, Parke Davis and Abbott

1932—Seventy-five years ago:
- Nevada Pharmacists Association formed
- Four-year course required to take state boards for registration

1907—One hundred years ago:
- Montana College of Pharmacy formed

By Dennis B. Worthen Lloyd Scholar, Lloyd Library and Museum, Cincinnati, OH.
One of a series contributed by the American Institute of the History of Pharmacy, a unique non-profit society dedicated to assuring that the contributions of your profession endure as a part of America's history. Membership offers the satisfaction of helping continue this work on behalf of pharmacy, and brings five or more historical publications to your door each year. To learn more, check out: www.aihp.org

North Carolina Pharmacist

Vol. 87, Number 3 ...applying drug knowledge to improve health Summer, 2007

Perspectives on Medication Reconciliation

Don't miss the largest pharmacy meeting in North Carolina:

NCAP's Annual Convention

October 28-30, 2007, Research Triangle Park, NC

More information on page 2

SAVE THE DATE: Oct. 28-30, 2007

NCAP's Annual Convention

Sheraton Imperial Hotel, Research Triangle Park, NC

This year's NCAP Convention includes quality CE for all pharmacy practice areas, a Medication Therapy Management Certificate Program, exhibits, a Residency Showcase, Award Presentations and Pharmacy School Receptions for Campbell, UNC and Wingate Universities. And, don't miss a special presentation by Clinical Psychologist Wayne M. Sotile, PhD, who will share his wonderful blend of wisdom and humor. Dr. Sotile is one of the most sought-after conference speakers and consultants today.

Topics for this year's Convention include: MTM – Update on What's Going on in North Carolina • Venous Thromboembolism Medicare Modernization Act • Managers Forum: "Top Grading" – Selecting & Retaining the Best Staff Pharmacogenomics "News/Media and its Effect on your Practice" • Using Technology for Quick Access to Drug Information • Pharmacy Quality Alliance- What it Means for North Carolina Pharmacy • Pearls for the New Practitioner • Thrombocytopenic Purpura: Treatment Strategies and First-line Therapies • Delivering Unique Pharmacy Services • Preventing Medication Errors: Applications of the IOM Report • Oral Health • Bisphosphonates, Systemic Drugs and Screening High-Risk Patients • Update on HIV & Secondary Infections • Diabetes, Its Complications, & Where the New Drugs Fit In • Smoking Cessation

Convention brochures will NOT be mailed this year.
More information available soon at www.ncpharmacists.org.

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North Carolina Pharmacist

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Inside

NCAP Offers Online Pharmacist Refresher Course

NCAP has partnered with the Connecticut Pharmacy Association to offer The Pharmacist Refresher Course, an online course designed for pharmacists who wish to return to community pharmacy practice after an absence from practice for three or more years. The course consists of three modules, all of which have been approved for ACPE credits. The first two modules are completely online and composed of weekly study segments that allow course participants to work at their own pace, on their own time. The third module consists of a three-week, 90-hour live experience in a community pharmacy. Only those who participate in all three modules will earn a Pharmacist Refresher Course Certificate from Charter Oak State College. Those taking modules One and/or Two for personal enrichment will earn ACPE credits through CPA.

and...

A Two-Week Online Pharmacy Law/QA Course

This course will give home study law credit to any pharmacist wanting to learn about quality assurance strategies and North Carolina's pharmacy laws. This course can be used to prepare for reciprocity into North Carolina, or for those who want an update on Pharmacy Law and Quality Assurance. Students must follow a two-week course schedule. Online discussion boards and instructor monitoring and interaction keep you on track throughout the course. The course is offered the first two full weeks of every month. The registration deadline is the Thursday before each monthly course starts. This course is accredited by ACPE for 15 hours of home study law education.

For More Information visit our Web site at www.ncpharmacists.org or Call NCAP at 919-967-2237.

Advancing NC Pharmacy

Summer is almost past, but the summer doldrums of years gone by have given way to summers passing faster, with busy times all year long. Perhaps it's just my age that makes time seem to fly by more quickly. Maybe my inability to say "no" makes my summer seem busier. Perhaps it is just a cultural phenomenon not unique to me at all. If we are not careful, however, this sense of constant activity can keep us from focusing on the important instead of the urgent. Let me try to apply this idea to NCAP as an organization.

Why does NCAP exist? Why are you an NCAP member? By supporting NCAP with your membership dollars, is what you want from the organization the same as what you need from NCAP? Too often what we want is the "urgent" and what we need is the "important." Whether this is true for you will be up to you to determine, but let me share with you my current thinking.

Many members might want us to protect their practice from external forces trying to change pharmacy as we know it. To them, lobbying and political action is the most important thing NCAP can do. Others might see educational programs that provide information on solving contemporary practice issues as most important. Both of these are useful but are they the most important things that we can do?

I have come to believe that helping pharmacists prepare to function in a new practice model is the most important thing that NCAP can do for our members and for the profession. Let me support this suggestion with these observations:

A. Not only is our health care system broken, but our pharmacy services model is filled with wrong incentives. In many of our environments we have a "pharmacy practice" model rather than a "pharmacist practice" model. What is the difference? I think there are many, but let me suggest a few.

When pharmacists engage in cognitive services, who bills for this? In a pharmacy practice model the pharmacy bills not the pharmacist and the pharmacist employer receives the payment, not the pharmacist. I would suggest that this results in misaligned incentives and often discourages implementation of cognitive service programs.

Another difference is in who the pharmacist sees as their employer. In a "pharmacy practice" model the pharmacist works for the employer, usually a corporation. In a "pharmacist practice" model the pharmacist works for the patient.

You may ask "why does the model matter?" I think it leads to suttle but significant differences in perception about the profession of pharmacy and in actions undertaken by pharmacists. In the "pharmacy practice" model the commercial dominates and pharmacists are seen as tangential players to the health care mainstream. In the "pharmacist practice" model, pharmacists assume essential roles as health team members. I admit that in many situations both models may be present for different services so it is not as black and white as I have made it.

B. A recent news release put out by the Pharmaceutical Care Management Association focused on a new member whose president was quoted as saying "we joined PCMA to be engaged in 21st century pharmacy practice." Although I wouldn't suggest that PBMs are offering acceptable pharmacist services, the statement has caused me to reflect. The world is changing, yet many pharmacy practices show little change in pharmacists' roles from when I entered practice 50 years ago. Shouldn't a "global economy," a "flat world," technological advances, or changing education platform lead to a different practice model for pharmacists?

C. If we are doing the "right thing" in pharmacy, why are legislators not hearing our message? Could it be the wrong message we are sending? Are we trying to hold on to our past rather than adopting a new future?

I plan to devote my last few years at NCAP in this pursuit. North Carolina is fortunate to have the Association of Community Pharmacy (ACP) carrying the legislative agenda of community pharmacy so well. We have a great regional chain in Kerr Drug that wants to promote a health care center image for their pharmacies and are evaluating new services and practice models. Our three pharmacy schools are engaged in the profession, not just in the education of students. We now have new leadership at the Board of Pharmacy.

None of these groups, on their own, can create a new practice model for the profession. NCAP is uniquely positioned to take on this role. Our organizational structure allows us to engage all practice segments. We are supportive of the work of others and are willing to cooperate to help them achieve their goals. Hopefully, no one sees NCAP as a threat to their activities. We can be the vehicle to represent pharmacists opinions and speak on behalf of them to non-pharmacy audiences. Perhaps more importantly we can be the catalyst to unite all these groups in developing, promoting and implementing a new practice model.

Yes, my summer went by quickly, but it has not kept me from reflecting on NCAPs important role in advancing NC pharmacy. This is how I see it. If I reflect what you think is important, I look forward to your help in making it happen. If you think I am off base, let's talk to see if we can come to some agreement.

Fred Eckel,
Executive Director

Dear NCAP Member,

This issue of the *North Carolina Pharmacist* features various members' experience with medication reconciliation. This particular patient care initiative is very near and dear to my heart and one that raises some critical considerations for our profession.

Regardless of practice setting, pharmacists and technicians undeniably agree that it is our responsibility to ensure that patients continue on the appropriate medications as they move through various settings throughout the continuum of care. Not only is it our responsibility, it's the *right* thing to do. I think all of us would also assume (at least hope) that if our own loved one transitioned from home to hospital to assisted living facility, one of the most basic aspects of their care would include ensuring that the appropriate medications are continued. Yet many pharmacists, at least in the acute care setting either do not view medication reconciliation as their responsibility or find it too inconvenient, for whatever reason, to make it their responsibility. So in most hospitals throughout the state and nation, nurses are taking the lead in this critical quality of care initiative. Like MTM in the community setting, many pharmacists are relinquishing responsibilities to other healthcare professionals. And unfortunately, this will come at the expense of both the profession and the patient.

In addition to the above, there are two other things that strike me about the medication reconciliation opportunity which are worth highlighting. First, many pharmacists have expressed the sentiment that "we already do med reconciliation; we just don't call it that." Yet, now that the process is more formalized and includes the responsibility to communicate the information to the next provider of care, those same pharmacists are seeing that the "traditional process" probably was not good enough for many patients. I will be the first to admit that medication reconciliation is not easy. Like most hospitals, we at Wake Forest University Baptist Medical Center have been intensively working on our initiative for two years now and still are not at 100%. Having said that, most members of our team would agree we are getting there. And even though it has not been easy, a wise person once said...*the things in life worth doing usually aren't easy.*

The other thing that strikes me about medication reconciliation (or whatever you want to call it) is that this responsibility/opportunity definitely crosses all practice settings – ambulatory care, acute care and chronic care. There has not been a patient care or professional initiative in recent memory that calls for the cooperation and collaboration of pharmacists across all practice settings. It is these situations that reinforce the value of a unified pharmacy organization. And in the end, the patient will ultimately benefit.

If you are a practicing pharmacist with direct patient care responsibilities, I hope this issue of the journal will inspire you to re-evaluate your role with regard to medication reconciliation. Specifically, ask yourself, *"Am I doing everything I can to ensure patients continue on the appropriate medications?"* If the answer is "no," seek the guidance of your peers within NCAP. As our mission reads, we exist *to unite, serve and advance the profession of pharmacy* to ultimately benefit the patients we serve.

Beth Williams, PharmD, BCPS
President

Perspectives on Medication Reconciliation

Pharmacists' roles are changing. The change is coming too fast for some, but not fast enough for others. One of the changing roles relates to medication reconciliation, our focus for this issue of North Carolina Pharmacist. *Some may think this is only a hospital pharmacy problem but the entire profession can benefit and contribute to the solution. Therefore, we asked pharmacy professionals representing different practice areas to contribute to this issue. First, Debbie Miller provides an overview of medication reconciliation and shares with us how Carolinas Healthcare System is trying to accommodate this new requirement. Jennifer Noped describes how North Carolina Baptist Hospital is responding to the requirement. They are utilizing selected pharmacy technicians to help accomplish medication reconciliation and Amelia Long, one of the Medication Reconciliation Technicians, describes her role in this effort. Jim McAllister shares his views about how the hospital pharmacist should approach this opportunity. Rebecca Chater offers the community pharmacist perspective, and Lori Edwards provides the perspective of a nursing home consultant pharmacist. To help us understand what type of information can be shared under certain circumstances, Jay Campbell offers a legal perspective. Finally, Holt Anderson offers a look into the future of the health information highway.*

Medication Reconciliation: A Primer

by Debbie Miller, PharmD, BCPS
Cardiology Clinical Specialist
Carolinas Medical Center

As you will read in this issue of *North Carolina Pharmacist*, "medication reconciliation" is a relatively new Joint Commission (JACHO) National Patient Safety Goal (NPSG) for those facilities it surveys. The intent of this article is to provide information on its basic requirements and to illustrate some ways it is being accomplished. As you can expect, our individual hospital practices vary too much for one standard process to work in all environments, which range from paper-based systems to physician order entry.

The actual language of the goal is deceptively simple:

"Accurately and completely reconcile medications across the continuum of care.

There is a process for comparing the patient's current medications with those ordered for the patient while under the care of the organization.

A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. ***The complete list of medications is also provided to the patient on discharge from the facility.***"

Actually meeting the goal is much more complex, and you will not find another NPSG that is accompanied by a 17 page FAQ document meant to clarify the requirements at the "nitty gritty" level. For Carolinas Healthcare System, the "continuum of care" has been particularly challenging as we are also implementing a new electronic medical record system, Cerner Millennium™, across many of our acute care and all of our ambulatory care facilities. The requirement to provide the patient a list of medications was added to the NPSG for 2007, greatly impacting our clinic patients.

Continuum of Care

Admission

The term "admission" refers to healthcare encounters, not just inpatient admissions. The first step (and one of the most challenging) is to obtain a list of the patient's medications. If I could spend all of NCAP's money, it would be to advertise on billboards across the state how important it is to for everyone to keep an accessible list of their medications, doses and frequencies! This basic information provides the platform for everything that follows. Also important is for the "history taker" to have some familiarity with the medications, and it is especially helpful if he/she can recognize incorrect doses or frequencies that require further clarification.

The list is typically handwritten on a special form or entered into a database that is either printed for MD action, or reconciled within the computer system. At Carolinas Medical Center (CMC), medications are written on a form, although JCAHO does not require this. We felt that a special form, kept in a sheet protector in the chart for easy identification, would best highlight the new process and provide an important reference tool while the patient is hospitalized. After much discussion and observation of other institutions' processes, it was decided that the form should also allow the medications to be ordered on admission, saving time and reducing possible transcription errors. Since we have found that home medications are often ordered on admission in this way, and due to confusion caused by the ability to also sign that the list has just been "reviewed," we are considering changing to a single physician-signature requirement. During our QA audits, we have found that use of the form to order the medications results in clear communication that medications circled "no" in the Order on Admission column have not been inadvertently omitted.

Transfer

We were fortunate at CMC that the transfer process was already in place prior to the medication reconciliation requirement. A list of current medications is printed for the physician to indicate what should be renewed or discontinued. The only change that was necessary was to ensure the transfer form was completed for patients transferring to higher levels of care, in addition to those moving to a lower level of care.

Discharge

At the time of discharge, the form completed on admission is removed from

the sheet protector in the chart, compared to the current medication list and updated by the physician who circles "yes" or "no" for each original home medication. The bottom section of the second page is used to list new or changed medications. Prior to institution of the medication reconciliation form, there were at least five different methods for physicians to document what medications the patient was to take at home. Nurses now have a clearer idea of what medications are to be written on the patient's discharge instructions form, which is then faxed to the next provider of care and copied for the chart. For hospitals in our system that utilize Cerner, a document that lists home and current medications is printed and the physician indicates which are to be continued at discharge. The nurse updates this information in the computer and prints a patient-friendly document that is faxed to the next provider and given to the patient. This updated Medication Profile can be accessed by others in the system and ultimately will become the main source of information about home medication histories as other hospitals and clinics begin using the electronic medical record system.

Outpatients

In February of this year, we added an outpatient procedure form at the request of our outpatient surgery center. It is designed for medications to be listed in patient-friendly terms and then updated following the procedure. The form is then faxed to the next provider, copied for the chart and given to the patient at discharge. In earlier pilots on our inpatient units, a similar form was tried but we found that the habit of writing medical abbreviations was too hard to break. The nurses who use the outpatient form are diligent about writing in patient friendly terms as this prevents them from having to rewrite the medication list at discharge. If a patient is admitted to the hospital, the list is copied onto the inpatient form.

Ambulatory Care

For those clinics already using the new electronic medical record system, home medications are entered into the Medication Profile section, which also can be used to fax new prescriptions to outpatient pharmacies. Patient-friendly lists can also be printed for the patient. Until this system is available in all clinics, medication lists will be written in two ways: 1) every chart has an Ambulatory Care Medication Record that lists home medications vertically and tracks them horizontally for each clinic visit, and 2) patients are asked to complete medication history forms which are then updated as needed at each appointment.

Miscellaneous Departments

The emergency department, cardiac cath lab, endoscopy, radiation therapy, radiology, dialysis and other outpatient areas have chosen the form and process (of the three options above) that best fit their practice environment. We are in the process of changing the outpatient procedure form to an outpatient *visit* form to facilitate use in areas other than our One Day Surgery center. Other considerations include pre-existing computer systems in some of these areas, none of which have been updated with a medication reconciliation component.

The paper process will suffice until Cerner (or an interface) is in place at all outpatient departments.

The medication reconciliation NPSG is an important step forward in improving our patients' knowledge of their medications, facilitating communication among care providers and reducing errors associated with inappropriate medication use for our patients. Regardless of a pharmacist's practice environment, everyone can contribute to making it a success for our patients. I would be happy to answer any questions and can be contacted at debra.miller@carolinashealthcare.org.

Samples of Carolinas Healthcare System Medication Reconciliation forms can be found at www.ncpharmacists.org.

The Driving Force: Improved Patient Safety and Quality of Care

by Jennifer Noped, PharmD, BCPS
Assistant Director of Pharmacy
Quality of Care and Patient Safety
North Carolina Baptist Hospital

When The Joint Commission National Patient Safety Goal (NPSG) addressing medication reconciliation across the continuum of care was introduced in 2004, communication began to swarm in the pharmacy community. Statements such as "this is huge" and "whose responsibility should it be?" were commonly heard throughout the country. As hospitals of all sizes began to evaluate processes and how to fully implement the goal by January 2006, even more questions and challenges began to arise. However, these issues allowed everyone to see the obvious reason this NPSG was created: health care providers in the hospital setting have a difficult time obtaining an accurate and complete home medication list at the time of a patient's admission. Also, ensuring that appropriate home medications continue during transition points in care like transfer and discharge is a challenge. The lack of this important medication information can contribute to medication errors.

The United States Pharmacopeia MedMARX medication error reporting database collected over 2,000 medication reconciliation-related errors in an eleven month time frame in 2004-5. The most common reasons for these errors at the time of patient admission, transfer, or discharge were improper dose, omitted medication, or a prescribing error. In addition, The Joint Commission reported in a Sentinel Event Alert in 2006 that of the 350 medication errors in its Sentinel Event database, 63% were due, in part, by communication breakdown. Based on data such as the above, the Institute for Healthcare Improvement (IHI), an internationally recognized organization focusing on improving the quality of patient care, included medication reconciliation to prevent adverse events as one of its key factors toward saving lives in its 100,000 Lives Campaign in 2005.

The Joint Commission and IHI provided

the spark needed to set hospitals into action. Although the initiative was recognized as important, putting a process into operation proved to be a tremendous task. Multidisciplinary teams were created in order to better understand current processes and what changes would be needed to insert medication reconciliation into those processes. In order to create a medication reconciliation program of the highest quality, all disciplines must be engaged in the planning, implementation, and monitoring process.

At most institutions, nurses and prescribers were identified as the most practical health care providers to complete medication reconciliation activities. Nurses can begin the medication reconciliation process by obtaining the home medication list at the time of admission. Then, prescribers reconcile the home medication list against their admission orders. This process is practical since it matches the current workflow of most institutions. However, many times nurses do not have the time needed to complete a home medication list in the manner in which The Joint Commission is expecting; in that, the list must contain the dose, route, and frequency for each medication. Also, they may not have the knowledge required to understand what the patient is describing as "that pink pill for my blood pressure." Lastly, prescribers may not be able to do a complete and detailed medication review due to their many responsibilities in caring for the patient.

Due to these limitations, institutions should evaluate the ability of the drug experts, pharmacists and pharmacy technicians, to play a key role in medication reconciliation. At North Carolina Baptist Hospital (NCBH) it was determined that the pharmacy staff would take responsibility for obtaining the home medication list upon admission. Also, pharmacists complete the reconciliation process at admission by comparing the home medication list to the admission orders received. Pharmacists are the optimal health care providers to be participating in these activities due to their extensive drug knowledge and training. High-quality pharmacy technicians can also get involved by obtaining home medication lists. Technicians obtain lists is a timely manner and take great pride in the service they are providing. The medication reconciliation technicians at NCBH go the extra mile by exploring all possible options, such as calling the hometown pharmacist, long-term care facility, etc, in order to ensure the most accurate medication list is obtained.

Many health care providers across the country have questioned why extensive resources should be spent on a NPSG with very little, if any, outcomes data available to support its value. At NCBH, however, we have realized the value of the medication reconciliation process through numerous medication errors that have been intercepted. For example, a pharmacy technician interviewed a patient complaining of fainting and dizziness in the Emergency Department. The technician took the time to carefully evaluate each of the patient's prescription bottles. Upon review of the bottles, and after a call to the patient's retail pharmacy, the technician confirmed that the patient was taking both Cartia XT 240 mg twice daily and Taztia XT 360 mg once daily. Another example of a medication error caught by the medication reconciliation process was that of an Emergency Department prescriber listing a patient's home medications to be albuterol, Advair, and Depakote. The list was taken from a past visit to a hospital clinic. The technician interviewed the patient and confirmed that the patient also took Lantus, Humalog, Norvasc, Zocor, and aspirin. Also, implementation of the electronic discharge process, which utilizes the home medication list obtained at admission by the pharmacy staff, has led to a more legible, complete medication list for the patient to take home. This information is also electronically communicated to referring prescribers. These efforts, although time consuming and labor intensive, can potentially save patients' lives through the prevention of medication errors.

> *"Medication reconciliation has changed the focus from what the patient is taking to what the patient should be taking."*
>
> - Michael Share, RPh

I believe that the overall quality of care provided to patients has improved with the implementation of the medication reconciliation program. At NCBH, it has specifically led to an improved quality of care that our pharmacy staff can provide. Our General Surgery Decentralized Pharmacist, Michael Share, RPh, said it best: **"Medication reconciliation has changed the focus from what the patient is taking to what the patient should be taking."** By being involved in this essential part of the patient's care, pharmacy staff can prove their value as being vital members of the health care team.

As the medication reconciliation process evolves and improves, the statements commonly heard when the NPSG was first introduced come to mind..."this is huge"- yes, it is. "Whose responsibility should it be?"- It has to be a shared responsibility, but pharmacy can play a lead role. Who better to be involved in a program that has safe, effective, and appropriate medication use as the focus?

The Role of the Pharmacy Technician

by Amelia Long
Medication Reconciliation Technician
North Carolina Baptist Hospital

One of the greatest challenges for North Carolina Baptist Hospital (NCBH) in the last year and a half has been defining a process for the Joint Commission National Patient Safety Goal of Medication Reconciliation. Obtaining home medication lists for every patient admitted to the institution is a rather daunting task; one that has been placed at NCBH, largely upon Pharmacy Medication Reconciliation Technicians.

The use of Pharmacy Technicians to obtain home medication lists has proven to be a safe, accurate, and efficient way to create, update, and confirm a patient's home medications. Since the Medication Reconciliation Technician position was created solely to obtain medication lists, many different resources are able to be utilized in collecting these lists. We are able to not only rely on a patient's own recollection of their medications, but are able to take the time to verify them with retail pharmacies, outpatient clinics, long-term care facilities, and family members. Pharmacy Technicians also possess a vast knowledge of commonly and not so commonly prescribed medications, not only the brand to generic equivalent, or standard dosing, but also size, shape, color, etc. In many cases, just knowing what a certain pill looks like is the difference between knowing its strength and not knowing. Also, many pa-

tients are more relaxed and less intimidated when dealing with Pharmacy Technicians, as opposed to a physician. In some instances they will offer more information on how they have been, or not been, taking their medication, which in turn will help their physicians better care for them.

A Medication Reconciliation Technician must possess certain qualities in able to perform their duties to the highest of patient care standards. Retail pharmacy experience is preferred, as we not only deal with patients and their families face to face, but we also need to know just about everything there is to know about oral medications. In the retail setting, technicians are more exposed to hands on experience with medications, such as handling pills and entering prescriptions. Medication Reconciliation Technicians must be highly skilled and efficient. We have to be self-motivated, able to multi-task, possess good verbal skills, and possess the ability to develop a professional bedside manner. Attention to detail is also a must. The Home Medication List is the starting point in the Medication Reconciliation process and the slightest mistake can make a difference in the safety of the patient.

At NCBH, the Medication Reconciliation Technicians are placed in three primary locations: the Emergency Department, the Pre-Operative Assessment Clinic, and the Outpatient Surgical Center. In addition, technicians obtain home medication lists from patients admitted as Direct Admissions throughout the institution. In the Emergency Department, our goal is to obtain histories from patients who are definitely being admitted to the hospital and those patients with a high acuity level who are more likely to be admitted. By focusing on the Emergency Department, we are able to obtain a large number of home medication lists before the patients go to the inpatient side of the institution. There is one technician stationed in the Pre-Operative Assessment Clinic who obtains medication lists from patients scheduled for elective surgeries. Home medication lists obtained in this way are available to clinicians for review several days in advance of the patient's actual admission. One technician is stationed in the Outpatient Surgical Center to obtain home medication lists on the remaining inpatient and outpatient surgery patients. Technicians also obtain medication lists on Direct Admissions, which are unscheduled admissions of patients by physician referral from a clinic visit or transfers from outside hospitals.

We also utilize a Scheduled Admissions list to identify patients scheduled for admission who will not be seen in the Pre-Operative Assessment Clinic. These patients are called at home and medication lists are obtained over the telephone, which sometimes proves to be the best way of obtaining an accurate list as the patient has their prescription bottles right at hand.

As you can imagine, we are faced with many challenges each day. The large patient census at NCBH, an 851-bed institution, versus just a handful of Medication Reconciliation Technicians (8 technicians over 3 shifts) proves to be the greatest challenge. We have also found that there is a very small "Window of Opportunity" for obtaining histories in the ED and as Direct Admissions. Very often it feels as if we are chasing patients throughout the hospital; trying to get to them before they go to X-Ray or right after they come back from the Cardiac Catheterization Lab. As of yet, we have been unable to identify an efficient way to capture a patient's home medication list at the exact point of admission to a unit. However, efforts continue to improve processes to eventually make these challenges our success stories!

Our process has come a long way since its initial pilot phase in October of 2005, and we hope that in the coming months, with the addition of new staff, we will see even greater progress towards a solid and permanent system.

Exciting Opportunity or Daunting Burden?

by Jim McAllister, MS
Director of Pharmacy
UNC Hospitals

Medication reconciliation represents activities for adjudicating prescribed drug therapy at all points of transition of care including hospital admission, transfers to or from acute care and intensive care, and at the time of discharge. From the hospital practitioner's point of view, the process begins with the most daunting activity, the documentation of a complete and accurate medication history. Admission medication history data are required as a baseline for all subsequent care transitions including transfers, discharge prescriptions, and subsequent return clinic visits. As we all know, obtaining an accurate and complete medication history can be challenging for many reasons.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) now requires accurate and complete medication reconciliation for all patients who are admitted for care. Hospitals are designing and implementing a myriad of diverse initiatives to become compliant with this reconciliation standard. Responsibility for reconciliation is often assigned to medical residents, admitting physicians, nurses, or pharmacists. It is fascinating that no profession has expressed widespread acceptance of this responsibility, seeing the JCAHO mandate as an unnecessary (or redundant) activity representing one more bureaucratic burden.

The medication reconciliation standard was promulgated to reduce medication errors and improve quality of care. I suspect that observations by JCAHO surveyors, including review of sentinel events, contributed to the decision to develop the standard, but publications and press releases from organizations such as the Institute for Healthcare Improvement and the Institute of Medicine also had an impact on its creation. One of the most frequently cited examples of errors which could have been avoided with a good medication reconciliation program was duplicate therapies. For example, a patient might have been prescribed a calcium channel blocker by his referring physician prior to admission. The admitting physician changes to a similar agent on admission and writes a prescription for the new agent at discharge. Following discharge, the patient takes the new calcium channel blocker and resumes taking the original blocker as well.

Since this particular standard was created I have heard the majority of pharmacy leaders and practitioners suggest that assuming these new responsibilities will require additional staff. I must admit that our original calculations at UNC Hospitals, based on a pilot study of 800 admissions, would require 10 to 11 additional pharmacists for taking medication histories on 33,000 annual admissions. While I remain convinced that additional staff will be required, especially as we initiate these new processes, I have come to realize that our health care system cannot accommodate the financial burden associated with adding large numbers of staff. Pharmacy staff and their leaders will need to rely on their creativity, technology, and perhaps even supportive personnel to accomplish this important endeavor. More importantly, we should re-examine current roles and responsibilities of staff to determine their relative priority in light of the

patient needs for medication reconciliation. Perhaps most importantly, all pharmacists need to recognize the value of medication reconciliation and its impact on the quality of pharmacist care it embodies.

As a profession, we are too frequently averse to change, especially on broad-based initiatives, preferring instead to maintain the status quo with which we are most comfortable. I suspect we feel this way because we are compulsive about the services we currently provide, uncompromising on the quality of our work, and assume that all we do is essential (or we wouldn't be doing it now).

While making the case for the profession to embrace its societal imperative for providing pharmaceutical care, Hepler and Strand concluded "Motive and opportunity for pharmacy's re-professionalization now coincide."[1] That sentence has never left me because it suggests that there are times when substantial change can take the profession a dramatic leap forward. However, the phrase also gave me a sense of professional urgency to take advantage of the situation before the opportunity slipped away. I suggest that the JCAHO mandate for medication reconciliation represents a similar opportunity when motive and opportunity coincide. Imagine, if you will, that the entire profession embraces medication reconciliation and assumes this responsibility (which is entirely consistent with the tenets of pharmaceutical care) and is recognized by patients, institutions, payers and providers for a substantial and clearly recognized improvement in the quality of care.

The Opportunity

Pharmacists who practice in acute care settings recognize that physicians who are pressed for time perform only a perfunctory medication history and, at the time of discharge, invest little time with the patient discussing how their pharmacotherapy has changed and what prescription changes have been made (and why) for their care after they return home. As Hepler and Strand noted almost 20 years ago, if the public knew what we know about drug related morbidity and mortality, it would not just ask that pharmacists institute preventative measures, it would demand such action.[1]

Whittington and Cohen reported that accuracy rates for medication reconciliation on admission in a large health care system measured about 40%.[2] During a pilot study at UNC Hospitals in which pharmacists reviewed physician admission orders for 800 admissions, we found that about one-third of these patients had admission orders that required intervention to avoid a significant medication variance.[3] These findings and others confirm a significant opportunity to improve the quality of care if pharmacists assume responsibility for medication reconciliation.

In addition to reducing costs associated with medication variances, medication reconciliation processes present an opportunity to optimize dosing, eliminate unnecessary drug therapy, and optimize therapeutic outcomes, all of which should further reduce the cost of care if not the cost of drugs. Similarly, the efficiencies gained with timely and accurate admission orders and discharge prescriptions should improve throughput and minimize average length of stay which also reduces the cost of care. Imagine the number of irritating calls to physicians which could be avoided if pharmacists were intimately involved in writing admission orders, thereby promoting formulary compliance, optimal drug product selection, and avoiding the prescribing admission errors which we know exist and which consume an inordinate amount of time to resolve.

Finally, assuming responsibility for medication reconciliation will substantially increase our time with the patients we serve. This is true for pharmacists practicing in the acute care setting, clinic environments, long-term care facilities and community settings. While I recognize the time required for these activities, it seems abundantly clear that patients will come to appreciate our value more, become our advocates, and again perceive us as an essential element of the heath care process rather than the facilitator for getting the drug products to the right place at the right time. The personal touch is incredibly valuable and will likely lead to realization by patients of other services we are fully capable of providing that will result in improving their health.

The Motives

As compelling as the opportunities are, there are important motives for assuming these new time-consuming activities. While providing pharmaceutical care is a goal we all aspire to accomplish, we have achieved success to varying degrees individually and organizationally. Medication reconciliation is so fundamentally basic and applicable in all practice settings that we have the potential to achieve a more widespread professional adoption and subsequently gain recognition by other providers, institutions and patients as an essential part of the health care team.

I believe we will make a measurable difference in improving quality of care and will become an even more valuable colleague to physicians. I envision a time in the near term when we begin writing admission orders which remain suspended until they are reviewed and co-signed by the admitting physician. The influence we have as a result of writing orders will be profound and highly valued by patients, hospital leaders and other providers for promoting efficiency and beginning the hospital care more rapidly. Similarly, we can improve discharge processes and improve outpatient care by writing discharge prescriptions that are more clear and accurate for signature by the physician. Patient counseling before discharge, supplemented by more proactive counseling during the prescription filling process will promote compliance and more effectively underscore the importance of the patient being an essential component of health care.

As acute care practitioners increase consistency of patient interaction and drug therapy oversight, we can ensure compliance with CMS pay-for-performance measures such as providing vaccinations for selected patient populations, smoking cessation initiatives, and post-MI prescription of a beta blocker, and other initiatives. Maximizing reimbursement for hospital stays will undoubtedly be recognized by hospital leaders and enhance our organizational value.

Finally, assuming these activities on behalf of patients and our institutions when other providers are unwilling or unable to do so will further underscore our value in the eyes of all those we serve and those with whom we practice.

Conclusion

Medication reconciliation represents a tremendous opportunity for evolution of the entire profession. By creatively approaching the opportunities it creates, our profession can become more integrated and our impact on patients' health can grow dramatically.

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Community Pharmacy:
A Partner in Medication Reconciliation

by Rebecca W. Chater, RPh, MPH, FAPhA
Director of Clinical Services
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Transitions of care within the health care continuum have long presented great risk for adverse drug events due to the absence of proper reconciliation of changes in drug therapy. Among other transitions, this has been particularly evident in the movement from inpatient to outpatient care, and vice versa, with the discharge planning process often inadequate. While a multitude of factors can be attributed to driving practice improvement at any given time—academia, the marketplace, practice itself, the regulatory climate, consumerism, the government—it seems the current source of momentum in medication reconciliation awareness and improvement is the Joint Commission. JCAHO's inclusion of medication reconciliation requirements as part of their accreditation standard for health systems has afforded opportunities locally, regionally, and nationally for community pharmacy to engage in thoughtful dialogue on the subject and become actively involved as a partner in the process.

Locally, the Triangle Medication Continuity Consortium (TMCC), led by Rex Healthcare, has convened a coalition of health care supporters and stakeholders, including representatives of community pharmacy, as well as primary care physicians, hospitals, nursing homes, assisted living facilities, insurance providers, government officials, academic institutions, information technology specialists, and marketing professionals with the goal of both establishing partnerships for process improvement and ensuring that each patient has an active medication list that is accessible at each point of contact within the health care system.

Regionally, through their Centers in Excellence in Research and Therapeutics (CERT), Duke researchers began a continuity of care study two years ago with medication reconciliation as a centerpiece. The project, entitled Patient Focused Intervention to Improve Long Term Adherence to Evidence Based Medications (PILOT: EBM), involves close collaboration between DUMC and multiple community pharmacies within their catchment area. The clinical pharmacist-investigator at DUMC is responsible for sharing the patient's discharge regimen with the community pharmacist, along with contact information for the patient's physicians. The goal of the project is to implement and test an intervention that more closely links the community pharmacist, hospital pharmacist, hospital physician, community physician, and patient to improve patients' adherence to their cardiovascular medications. The community pharmacist's role in this project is central to identifying adherence problems, attempting to resolve problems with the patient, and, if necessary, alerting other members of the health care team to non-adherence. While the study is still in progress, it serves as a great example of improvement in the continuity of care process.

Nationally, there are several efforts underway to advance medication reconciliation. In April, a joint APhA/ASHP Continuity of Care Workgroup was convened including thought leaders in this area from hospital, community, academia, managed care, and long-term care. The charge of the workgroup is to develop a consensus definition and vision statement for medication reconciliation on behalf of the pharmacy profession. A modified Delphi process is being utilized to accomplish these objectives.

In May, a multidisciplinary national conference was convened, lead by ASHP, for the purpose of identifying a minimum data set for a personal medication record (PMR) and developing a social marketing campaign around importance of accessibility of a current, comprehensive personal medication list at all transitions within the health care continuum. Thought leaders from all disciplines within pharmacy, medicine, nursing, physician assistants, consumer advocacy groups, case manager organizations, quality improvement organizations, academic institutions, public and private sector researchers, and health systems were gathered around the table. The PMR was acknowledged to be a prerequisite to effective medication reconciliation.

Each year, the American Pharmacists Association Foundation brings together a group of pharmacy leaders the day following its Pinnacle Award presentation in Washington, DC for discussion and recommended direction around a profession-wide theme of great importance. This year's APhA Foundation 2007 Pinnacle Advisory Panel topic was medication reconciliation. The deliberations and recommendations of the panel will be reported in a publication by the APhA Foundation within coming months. This year's group included representation from community, hospital, academia, managed care, and long-term care pharmacy.

Each of these efforts underscores the need for leadership on the part of pharmacists and the pharmacy profession, in collaboration with other health care providers, in improving the medication reconciliation process. With more patients receiving their medications from community pharmacies than any other source, it is imperative for community pharmacists to work collaboratively with our colleagues in hospital and other areas of practice to develop and implement reliable systems around medication reconciliation to improve patient safety.

A Perspective From Long-term Care

by L. Edwards, PharmD, CGP, CP.
Consultant Pharmacist
Neil Medical Group

Medication reconciliation is a requirement in long-term care settings under CMS regulations and guidelines. It is the first step a consultant pharmacist takes when reviewing a new admission to a long-term care facility. This review is very comprehensive and considers all aspects of pharmaceutical care as the patient transitions from an acute care setting into the long-term care environment where they will be followed at least monthly by a consultant pharmacist.

The initial review, or initial drug regimen review as it is referred to, is the first documentation of review by the consultant pharmacist. The process begins with the consultant pharmacist reviewing the hospital discharge summary and any MD notes to understand what precipitated the hospitalization. After a review of the hospital discharge summary and pertinent lab work, the consultant pharmacist puts together the course of events that lead to the admission to the long-term care facility to gain an understanding of the patient's situation in the facility. They may be admitted on a short term basis following a hip replacement or admitted for life placement secondary to worsening dementia and the inability to care for themselves.

The next step usually involves writing down the problems or diagnoses and then matching up the medications from the discharge summary and long-term care admission orders. During this process any discrepancies from discharge to long-term care facility should be addressed in order to determine if an order was missed, changed or incorrectly transcribed.

Then the problems and diagnoses are matched with the medications (i.e., Dx = Rx). The consultant pharmacist will address any irregularities to the MD or director of nursing in a written consult. Clinical issue irregularities such as diagnoses which do not show a treatment ordered (e.g., Vitamin B12 deficiency and no B12 ordered) will be addressed to the physician. Those issues which have more to do with nursing concerns such as giving a medication with food for example, will be addressed to the director of nursing.

The consultant pharmacist will also have to prioritize the consults into what must be addressed now and what may be followed up at the next month's visit.

Other aspects of care the consultant pharmacist will review will be physiological factors, lab work, how medications are being given and whether or not there are any absolute or relative contraindications that exist with therapies. The consultant pharmacist will assess the current status of the resident and make recommendations as well as formulate a plan for the next month when the patient is reviewed again.

When a patient is transferred to an acute care setting, the consultant pharmacist is usually not aware of the transfer immediately. Since consultant pharmacists are required to review the resident once a month, they may not be physically present at the time of a patient transfer. The way in which a consultant pharmacist may assist the hospital staff is if their initial drug regimen review or progress notes are made available to the hospital staff. If these reviews could be accessed by hospital staff, it may answer some of the clinical questions. For example if a hospital pharmacist were able to review a consultant pharmacist's progress note it may provide valuable information as to why the patient is being admitted to the acute care setting. It would provide that continuum of care that is often spoken about.

This process could be facilitated by simply changing what is required in the hospital admission process. Though there are some differences between what hospitals may require from the long-term care settings, usually documents such as the current medication administration record, admission face sheet and current labs are part of what is used to admit patients. The hospitals can ask for the consultant pharmacist's note in addition to other documents. These notes are usually abbreviated and represent several months of clinical review. The information contained could be very important to the hospital pharmacists who will be reviewing and assessing some of the same issues and concerns. If need be, they could contact the consultant pharmacist for consultation. Many times consultant pharmacists have contacted hospital pharmacists for information on drug dosing, labs and order clarification. Contacting the consultant pharmacist could work for the hospital pharmacists as well.

Both hospital and consultant pharmacists would benefit from an exchange of information. Many hospitals have local long-term care facilities they regularly admit patients to for assorted reasons. They could routinely send their medication reconciliation reviews along with other documents required for admission to the long-term care facilities. With facility coordination and cooperation the hospital medication reconciliation reports could be routed to the consultant pharmacist to review when they are in the long-term

care setting and ready to review the new admission. Any unanswered questions at discharge from the acute care setting could be picked up and addressed by the consultant pharmacist at the long-term care facility. This will all require collaboration between institutions as well as an understanding of how the two entities (long-term care settings and acute care settings) impact one another and can improve outcomes with improved communication.

Privacy Statutes No Barrier To Medication Reconciliation

by Jay Campbell, BS, JD
Executive Director
North Carolina Board of Pharmacy

It's obvious that an effective medication reconciliation program requires pharmacists and other health care providers to share patient-specific health information in an open and candid way. The problem I see all too often, however, is that when anybody starts talking about sharing health information, there's an almost Pavolovian denial and fear response among pharmacists. Why? My guess is that when HIPAA first hit the scene, many pharmacists (and other health care providers) were subjected to scare tactic lectures from administrators with no legal training at all or, at best, an extremely poor understanding of HIPAA and state-law privacy statutes. I think specifically that many administrative types – fearful of the statutes and daunted by the prospect of parsing their language – simply decided that no one could get in trouble for going well beyond whatever those statutes could possibly require in terms of protecting health information. And that's probably true from an administrator's "CYA" standpoint. But it's hardly true from a patient treatment standpoint. To the contrary. Failure to understand what restrictions on the sharing of patient health information do – and, as or more importantly, don't do – threatens effective patient care.

Lest anyone think that I am suggesting that pharmacists or other health care providers should approach HIPAA and state law -based patient privacy protections casually, let me dispel that notion right now. Compliance with such requirements is the law and, to my way of thinking, makes good policy sense. We live in an age where poor attention to the protection of patient privacy can carry devastating consequences. And those consequences tend to be much harsher and of longer duration for the patient than for the health care provider that fails to follow the law. Reasonable people may disagree on the merits of particular operational details in HIPAA and other privacy protections. But the broader issue of whether patient records are worthy of serious protection does not seem to me worthy of serious debate. Such legal protection rightly orients health care practitioners to the important privacy values at stake where patient records are concerned and provides appropriate incentives to ensure that those values are afforded the respect they deserve.

That said, what HIPAA and state law privacy statutes are not intended to do – and, if understood and applied correctly, do not do – is raise barriers to the sharing of patient information among treating health care professionals. Let's take them in turn.

HIPAA. I often tell pharmacy students in my classes that there seems to be a prevailing view that HIPAA is an ogre lying in wait under a bridge waiting to snatch well-meaning pharmacists laboring to treat their patients. It's just not so. HIPAA's implementing regulations specifically provide that a pharmacist may disclose "protected health information" or "PHI" (which prescription records certainly are) for purposes of treatment. And "treatment" under HIPAA is a broad concept that encompasses things like patient counseling, building patient profiles, and consulting with other treating health care professionals. Medication reconciliation fits comfortably within this framework.

From time to time, I have heard pharmacists express an opinion that even if they are allowed to share PHI for purposes of treatment, they are only allowed to share the "minimum necessary." This is wrong. The "minimum necessary" HIPAA restriction does not apply when PHI is disclosed for purposes of treatment. And how could it be otherwise? How, exactly, could treating health professionals be expected to determine what the "minimum necessary" amount of information would be to provide appropriate treatment? **Proper treatment depends on more information, not less.**

North Carolina Pharmacy Practice Act. Our Pharmacy Practice Act imposes some privacy restrictions that are more strict than HIPAA. HIPAA, it must be remembered, sets a floor, not a ceiling, on privacy restrictions. States remain free to impose additional or different privacy protections. But while our Pharmacy Practice Act may be more stringent in some ways than HIPAA, it imposes no additional barriers to sharing information necessary for medication reconciliation.

The Pharmacy Practice Act itemizes 14 specific disclosure allowances and one "catch-all." The relevant, specific permissive disclosures are to: (1) a "licensed practitioner who is treating the patient for whom the prescription was issued"; and (2) a "pharmacist who is providing services to the patient for whom the prescription was issued." Plainly, these exceptions allow the disclosures necessary for medication reconciliation.

Is protection of patient privacy important? You bet. Does the law require careful attention to the protection of patient privacy? Absolutely. But what the law does not do is stand in the way of effective patient treatment. Indeed, to quote Charles Dickens' Mr. Bumble, if HIPAA and analogous state statutes impose privacy-based barriers to effective patient care, then "the law is an ass." We can all come up with great examples of a law deserving of that characterization. But HIPAA and the privacy protections encoded in the Pharmacy Practice Act are not.

Riding the Information Highway: Unraveling the Acronym Soup to Get Pharmacists Where They Want to Go!

by Holt Anderson,
Executive Director
North Carolina Healthcare Information and Communications Alliance

The Federal Government is encouraging the transition from primarily a paper-based method of health and care to one based on electronic health records that may be exchanged electronically among organizations involved in treatment public health and research. The activities of the administration related to this goal are led by HHS[1] and fueled by means of grants and contracts administered through a number of its agencies (CMS[2], AHRQ[3], CDC[4] and ONC[5]).

The primary focus of the efforts so far is to promote the use of HIT[6] and HIE[7] via a

secure network-of-networks that eventually will become the health and care equivalent of the Interstate Highway System. Known as the NHIN[8], it will be built community by community with the goal of providing better quality and care by facilitating the secure exchange of information critical to the accurate diagnosis and management of conditions. A major desired outcome of the system is an avoidance of preventable errors by providing knowledge of current medications, allergies and existing conditions to professionals engaged in the care of an individual.

Especially relevant to pharmacists are several of the "Use Cases[9]" that have been developed to drive the NHIN architecture design and functionality by the AHIC[10] which serves as a guiding board for the Secretary of HHS. These include "Medication Management" that includes the following elements:

- Inpatient Medication Reconciliation
- Access to Current Medication and Allergy Information in an Ambulatory Care Setting
- Prescribing Process in an Ambulatory Care Setting

The 2006 "Harmonized Use Case for Consumer Empowerment" utilizes PHR[11] technology that allows an individual to control a record of their registration information and medication history and to allow providers permission to view that information.

The "Emergency Responder Electronic Health Record" Use Case is designed around a mass disaster scenario (e.g. Katrina) where access to information including pharmacy supplies and available beds is critical.

Medications also are a part of the other Use Cases as well, but the three mentioned above are where the major focus is at this stage of the NHIN development.

The transformation from a paper-based system of care to one that has access to information from multiple settings will not be an easy one but, in addition to developing the NHIN, there are additional efforts underway to harmonize standards through the HITSP[12], certify applications (e.g. electronic health and medical records systems) through CCHIT[13], and develop consistent and understandable laws and regulations that govern the privacy and security of information. HISPC[14] is a joint contract between AHRQ and ONC that is administered by RTI International in Research Triangle Park in collaboration with NGA[15] that is directed to understand what laws, regulations, and business practices constitute barriers to the electronic exchange of information critical to the health and care of individuals.

The North Carolina Healthcare Information and Technology Alliance, Inc.[16] (NCHICA) was established by Executive Order of the Governor of NC in 1994 with a mission of "improving health and care in North Carolina by accelerating the adoption of information technology." We are proud that the NC Association of Pharmacists, the NC Board of Pharmacy, and other professional associations, providers, government agencies, payers and vendors are part of our effort to achieve this mission. NCHICA, four of our hospitals[17] and a number of clinics, labs, SureScripts, and patients were involved in Phase I of the NHIN and we are involved in a submission to participate in Phase 2 of the NHIN that includes the Use Cases and development of a statewide HIE[18] that will connect pharmacists, physicians, hospitals, public health, long-term care, and others that participate in the care of North Carolinians.

The movement toward electronic exchange among business partners is sure to continue and even accelerate. The voice of pharmacists needs to be heard in every venue where policies, procedures, and technology solutions are being formed and each of the

groups mentioned have been found to be most receptive to receiving comments and input from every affected sector in health care. Get involved and on the road for better health outcomes by getting the right information to the right place at the right time!

Acronym Soup Unraveled:

[1] **HHS** – US Department of Health and Human Services
[2] **CMS** – Centers for Medicare and Medicaid Services http://www.cms.hhs.gov/
[3] **AHRQ** – Agency for Healthcare Research and Quality http://ahrq.gov/
[4] **CDC** Centers for Disease Control and Prevention http://www.cdc.gov/
[5] **ONC** - Office of the National coordinator for Health Information Technology http://www.hhs.gov/healthit/onc/mission/
[6] **HIT** - Health Information Technology
[7] **HIE** - Health Information Exchange
[8] NHIN - Nationwide Health Information Network
[9] Web site with all Use Cases - http://www.hhs.gov/healthit/usecases/
[10] **AHIC** – The American Health Information Community http://www.hhs.gov/healthit/community/background/
[11] **PHR** – Personal Health Record
[12] **HISTSP** – Health Information Technology Standards Panel http://www.ansi.org/standards_activities/standards_boards_panels/hisb/hitsp.aspx?menuid=3
[13] **CCHIT** – Certification Commission for Health Information Technology http://www.cchit.org/
[14] **HSIPC** - Health Information Security and Privacy Collaboration http://www.rti.org/page.cfm?objectid=09E8D494-C491-42FC-BA13EAD1217245C0
[15] **NGA** – National Governors Association Center for Best Practice
[16] **NCHICA** – www.nchica.org http://www.nga.org/portal/site/nga/menuitem.50aeae5ff70b817ae8ebb856a11010a0/
[17] Duke, FirstHealth, Moses Cone, Morehead Memorial
[18] **Health Information Exchange** Rx

Triangle Medication Continuity Consortium Holds Inaugural Meeting At Rex Healthcare

The inaugural meeting of the Triangle Medication Continuity Consortium on July 12, 2007 brought the leadership from all areas of health care together to literally sit at the same tables and come to a common understanding of a problem that plagues us all.

The Problem:

Health care providers' ability to provide optimal medication therapy regimens is compromised because:

- Patients do not always know what medications they are taking or should be taking.
- Health care providers rely significantly on the patient for this information.
- Communication between health care providers is limited.

The Consortium members include representatives from retail pharmacy, hospitals, nursing homes, insurance, information technology, government, academia, and health care professional societies. Prior to the meeting, individual interviews were conducted with 35 members of the Consortium and a survey was taken. The summarized results provided a factual starting point for discussion.

A new concept, "medication continuity," has been coined by this group. It is the ability to obtain complete and accurate information about a patient's medication regimen at each point of contact with the health care system. This is the necessary first step in the "medication reconciliation" and "medication therapy management" (MTM) processes.

Remarking on the success of the inaugural meeting, Christine Zone, PharmD, coordinator of the Consortium, said, "It was fascinating to watch these stakeholders approach a common problem from so many different perspectives. Everyone fervently agreed on the significance of the issue as it related to their area of expertise, and everyone resolved to work toward a solution in order to provide the highest quality of health care for patients."

The scope of this project focuses on obtaining correct patient medication information. By geographically restricting the range to the Wake County area and triangle hospitals (Duke, UNC), the coalition is setting out to solve a global problem on a local level.

GOALS OF THE TMCC:

- To develop a regional consortium to build partnerships for medication continuity process improvement
- To ensure each patient's current, active medication list is accessible at each point of contact with the health care system.

The next steps toward success for the TMCC is to develop a board of directors, and begin to evaluate potential solutions to the medication continuity problem against the criteria established by the group. In the short term, the TMCC recommends:

- Health care providers and supporters must strongly encourage patient responsibility for maintaining and carrying a list of medications.
- Health care providers must educate patients on the value of presenting the medication list to health care professionals, including pharmacists, nurses, and prescribers. Specifically, an accurate list is necessary to assure optimal drug therapy regimens, reduce the risk of drug-drug interactions, drug duplications, preventable adverse drug reactions, and to reduce the total costs of health care. Rx

Special Continuing Education Supplement

In order to better serve our members, NCAP will mail a special CE supplement only to members who request it. If you would like to be added to the CE mailing list please contact Teressa Reavis at teressa@ncpharmacists.org or call 919.967.2237 ext. 22

Are You Boiling Frogs?

by Bob Cisneros, PhD

Okay. A boiled frog. What does that have to do with pharmacy or patient safety? Actually a great deal! In his book *The Fifth Discipline*, Peter Senge discusses "learning disabilities of organizations."[1] Among those he described were: (1) a staff only knowing about their own job responsibilities and not understanding how they fit into the big picture of the organization and (2) an organization which always blames outside factors as causes of problems rather than looking in the mirror. But what may be the most intriguing disability, and my favorite, is what Senge describes in the "Parable of the Boiled Frog."

As the parable goes, if you place a frog in boiling water it will immediately jump out because of the temperature of the water. But if you place the frog in cool, refreshing water first and then turn the temperature up to boiling, the frog won't know anything is wrong until it is too late. A moral of the story is that you better take the temperature of your workplace regularly if you want to avoid finding yourself cooked. You may not notice when the temperature starts changing! You have to know what areas need improvement, where areas of weakness are. Otherwise one may not know anything is wrong until it is too late, much like the poor frog. Once a person gets used to the way things are it may be difficult to know when changes are needed.

Senge provided a very real example of the consequences of not "taking the temperature" of the working environment.[1] Detroit automakers ignored the threat of the Japanese car industry. The Japanese market share of autos rose from less than 4% during the early 1960's to nearly 30% by 1989. Was any American automaker paying attention or looking ahead? Apparently not.

Consider the Challenger explosion. This tragedy might not have happened if NASA had been paying attention to both the changes occurring in O-rings during previous cold weather launches and/or the warnings of one of its engineers just hours before the launch.

Are we just as guilty in pharmacy of not monitoring our own systems? The Pharmacy Quality Assurance Protection Act, passed by the NC Legislature last year, is an effort to assure that pharmacies are indeed monitoring, and improving, the quality of the pharmacy services that are being provided.[2] The North Carolina Association of Pharmacists (NCAP) is currently making available to community pharmacists a quality assurance program known as PQC (Pharmacy Quality Commitment), a system which allows a pharmacy to track quality measures, such as workload, medication errors and near misses. PQC provides the feedback needed for a pharmacy to monitor, identify, and correct problems and potential problems. For more information check the NCAP Web site (www.ncpharmacists.org).

Ken Baker, a developer of PQC, described a situation which is all too familiar for some of us: "Every pharmacist has at one time or another awakened in the middle of the night with the thought of 'Did I do it right?' "[3] Baker is very much an advocate of every community pharmacy having a continuous quality improvement system in place.

PQC is a fine system which a pharmacist may use. Other systems exist also and as Baker mentions, a pharmacy could even develop its own system.[3] The important thing is to have an organized approach to check the temperature of your pharmacy practice, document what you find, and use that information as feedback to improve the quality of your pharmacy processes.

Monitoring our pharmacy practice can be done in many ways. Here are just a few examples.

Medication Errors. Probably the most obvious and critical use of an ongoing monitoring program is to identify, document, and monitor medication errors and near misses. But having this information alone is not enough. Filing it away is reducing its value. The information has to be used as feedback to improve a pharmacy system. An ongoing monitoring and documentation program is critical and is now required by the NC Pharmacy Quality Assurance and Protection Act.[3] There are excellent resources that can be used including the Institute for Safe Medication Practices (www.ismp.org) and SecondStory Health (http://www.secondstoryhealth.com).

Computer Systems. Have you checked your computer system lately? Taken its "temperature?" The Institute for Safe Medication Practices (ISMP) conducted a computer survey just a few years ago. The survey and results are available online at: http://www.ismp.org/Survey/Survey200505R.asp. The survey asked hospital pharmacists to create an imaginary patient in their computer systems and enter several drug orders (and related patient information) which were known to be dangerous and had resulted in patient harm. The purpose was to see if the computer systems would signal a warning. The ISMP provided the drug orders and information to be used.

The results were disturbing. Few computer systems flagged all the orders. Some obvious problems were not detected. For example, an inappropriate order for "Methotrexate 7.5 mg. daily for rheumatoid arthritis" (a potentially fatal overdose) was only flagged by 29% of the computer systems tested. Should a pharmacist know that this is an overdose? A definite YES. Would a pharmacist in the midst of checking and dispensing hundreds of prescriptions daily catch this overdose if the pharmacy's computer system did NOT flag it? We hope.

How can we monitor the quality of our computer systems? One possibility is to check a computer system using the same orders used in the ISMP study. A different set of problem orders could even be created. This could be done on a regular basis as part of an ongoing quality assurance program with the results documented and used to improve the system. This might be a great ongoing project for students or technicians to be involved with (don't overlook the value of students and techs in providing manpower to help with these types of activities). If important things are not being flagged, the ISMP recommends communicating with the ven-

dor. Often the reverse is dangerous. Many insignificant flags may lead to a pharmacist accidentally bypassing a significant warning. Again, communication of concerns with the vendor is critical.

Is it important to monitor those tools we use to help with workload? You bet it is. It could be as basic as a random weekly or monthly check of automated dispensing machines. Are the right drugs located where they are supposed to be? Or perhaps a check of the computer system to see if dangerous interactions etc. are being flagged? This is just one tool in helping assure the quality of our system.

Staff Meetings. The pharmacy staff meeting may be one of the most unsung quality assurance tools we have available to us. A staff meeting used only as a general announcement session is a missed opportunity. In addition to announcements, staff meetings could be used to brainstorm and identify potential problems or near misses, and in general gather information about what could be done better. A question which could be asked at a staff meeting (particularly after the recent medication error documentary on national television) is: "If an undercover camera was brought into our pharmacy what would it see?" This could generate a discussion not only of potential problems but also all the good things that no one ever gets credit for!

Staff meetings can be used for "simulations" or discussions of such things as: what to do in case of...a fire? robbery or shoplifting? discovering that the wrong drug was dispensed to a patient? an irate, intimidating patient or physician on the phone? If you really wanted to take a chance, have someone call in and play the role of an angry person!!

Your pharmacy's temperature? We must always be aware of the temperature of our workplace and environment. Without it we may never know what we are doing wrong or right. A commitment to continuous quality is critical. Knowing the temperature of the water might have saved the frog. Regularly taking the temperature of our workplace can improve our services and the quality of care we give to our patients. Rx

"The moral of the story is that you better take the temperature of your workplace regularly if you want to avoid finding yourself cooked."

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Campbell Pharmacy School Honors Cary Pharmacist

For over 50 years, Ashworth Drugs has been an institution in Cary. More wisdom has been dispensed over the store's formica lunch counter than all of the pimento cheese and chicken salad sandwiches combined, according to Paul Ashworth, son of founder Ralph Ashworth. More important, Ashworth's still retains its old-fashioned approach to service.

On Tuesday, May 8, the Campbell University School of Pharmacy honored 74-year-old Ralph Ashworth with the M. Keith Fearing Community Pharmacist Award.

"My husband always said that there are three qualities that make a pharmacist successful—strong commitment, compassion and professional participation," said Lib Fearing, widow of M. Keith Fearing, one of the founders of the Campbell School of Pharmacy. "If you can provide all three of these qualities you have served the profession well."

Born December 20, 1932 in Fuquay Springs, NC, Ralph Ashworth received a Bachelor of Science in pharmacy from the University of North Carolina at Chapel Hill in 1955. He moved to Cary and bought the pharmacy in 1957.

"My father's mission was to always be useful to others," said son Paul Ashworth, manager of the pharmacy. "When a customer called in the middle of the night because his or her child had an ear infection, dad's answer was always, 'Yes, whatever you need.'"

The Campbell University School of Pharmacy presents the M. Keith Fearing Award to Cary pharmacist, Ralph Ashworth. From left, President Jerry M. Wallace, Lib Fearing, widow of M. Keith Fearing, Ralph Ashworth and his wife Daphne, and Ronald Maddox, dean of the School of Pharmacy. (Photo by Bennett Scarborough)

Through his participation in the Cary Area Chamber of Commerce, Ashworth helped spearhead many town projects, including the YMCA, The Carying Place shelter and Veterans Freedom Park. He was named Cary citizen of the year in 1976 and in 1992, shared honors with his wife Daphne as Cary co-business leader of the year. Ashworth received the 1992 Pharmacist of the Year award from the North Carolina Pharmaceutical Association and was recently named "Tar Heel of the Week" by the *Raleigh News & Observer*.

The M. Keith Fearing Community Pharmacy Practice Award is given in memory of M. Keith Fearing, a 1941 alumnus of Campbell who was instrumental in the establishment of the Campbell University School of Pharmacy. The Fearing Award was established in 1997 to honor Fearing's memory and his contributions to community pharmacy practice.

Grants Support Minority Pharmacy Program, Community Pharmacy Foundation at CU

The Campbell University School of Pharmacy has announced the award of a $120,000 grant from the North Carolina GlaxoSmithKline Foundation to fund a program for minority pharmacy students. Now in its second year, the Pharmacy Readiness and Enrichment Program or (PREP) is designed to prepare motivated minority students for entrance into the School of Pharmacy and to make them aware of the

many career opportunities available in the pharmaceutical industry.

Campbell University School of Pharmacy has also announced a grant in the amount of $27,526 from the Community Pharmacy Foundation. The grant will be used to benefit Campbell's Wellness Institute in the development and implementation of a diabetes education and self-management program for middle school children. The program seeks to combine the resource available in the Harnett County schools and local community pharmacies. Three Harnett County pharmacies will participate in the project—Thomas Drug Store in Dunn, Coats Pharmacy and Angier Discount Drug.

Wingate University Awards Honorary Degree to David Work

Wingate University President Jerry E. McGee awarded the Honorary Doctor of Humane Letters to David R. Work of Chapel Hill during the university's commencement ceremony on May 12. The award coincided with the graduation of the 355 students, including the School of Pharmacy's Charter Class.

Work is Executive Director Emeritus for the North Carolina Board of Pharmacy and has taught pharmacy law and ethics at UNC-Chapel Hill.

David Work at left with Dr. Jerry E. McGee, president of Wingate University

He is a graduate of the University of Iowa with a degree in pharmacy and a law degree from the University of Denver.

Among his many accomplishments, Work served as a pharmacist and was a corporation lawyer for Blue Cross in Chicago. He is a former President of The National Association of Boards of Pharmacy and the Chapel Hill Chapter of The United Nations Association. He is the 2004 recipient of the Hubert H. Humphrey Award from the American Pharmacists Association for exceptional service in government and public policy.

Wingate University School of Pharmacy Doctoral Degree Receives Full Accreditation

The Wingate University School of Pharmacy doctoral degree has received full accreditation from the Chicago-based Accreditation Council for Pharmacy Education.

On June 22, the Accreditation Council for Pharmacy Education reviewed the final post-graduation report of the school presented by founding Dean Robert Supernaw and Wingate University Executive Vice President Charles Taylor. The council awarded full accreditation to the school effective immediately.

Maddox Appointed to NC IOM, Will Also Mentor ALFP Program

Ronald Maddox, dean of the Campbell University School of Pharmacy, has been appointed to the North Carolina Institute of Medicine (NC IOM) by Governor Mike Easley.

The NC IOM provides nonpartisan information on complex health issues facing the state and strives to develop workable

solutions to these problems. Over the past five years, the NC IOM has studied ways to expand health insurance coverage to the uninsured, how to prevent child maltreatment and how to improve worksite wellness and increase the supply of nurses in the state, among many other issues.

Maddox will serve a term of five years as a member of the institute, which includes experts from government, education, business and industry, health and legal professions, the private sector, philanthropy and the public at large. Governed by a board of directors which meets quarterly, the institute fosters research, review and education through collaborative efforts with established centers and agencies within North Carolina, drawing on the expertise of the major universities, governmental units and the private sector.

Maddox has also been invited to be a Dean Facilitator for the 2007-2008 Academic Leadership Fellows Program (ALFP) sponsored by the American Association of Colleges of Pharmacy (AACP). Established in the 2004-2005 academic year, the goal of the ALFP is to address and solve the many challenges facing pharmacy education, including understanding the complex relationship between the health care system and society, building inter-disciplinary professional teams to serve the community, addressing and impacting legislative challenges and assuring excellence in the teaching and clinical application of core competences in primary health care services.

"The ALFP program is designed to develop the nation's most promising pharmacy faculty for roles as future leaders in academic pharmacy and higher education," said Arlene Flynn, vice president for Professional Affairs for the AACP.

To date 83 faculty from 51 different institutions have completed the program and 29 Fellows and five deans of pharmacy are expected to participate in the 2007-08 program, Flynn added. Dr. Ted Matthews, dean of the Mercer University Southern School of Pharmacy and a participant in the 2006-07 program strongly recommended it as an investment in the future of pharmacy education. Rx

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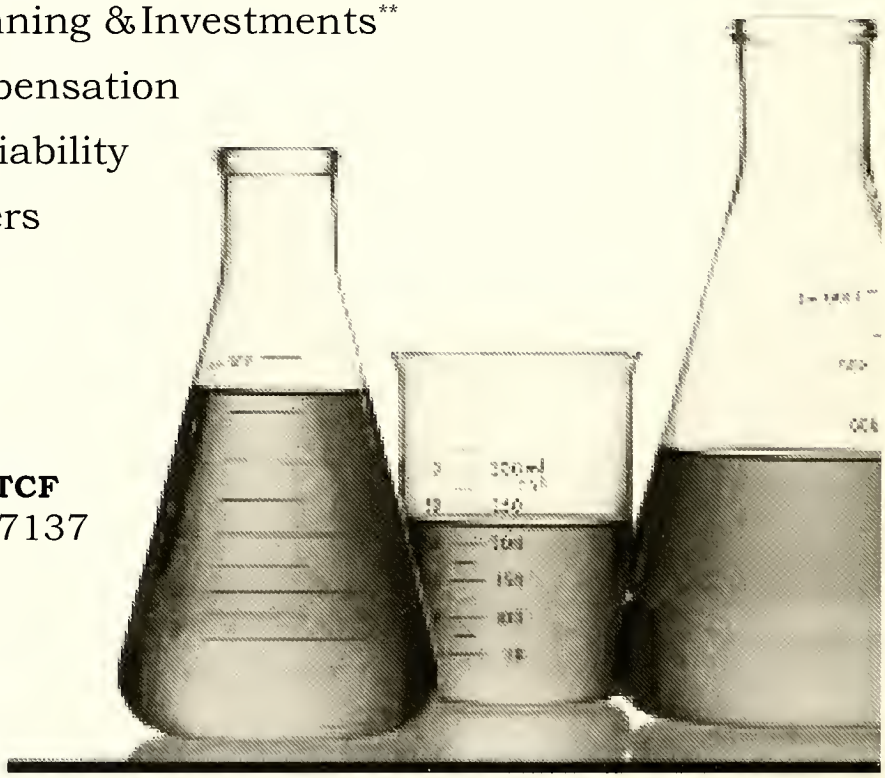

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Pharmacy Time Capsules

1982—Twenty-five years ago:

• Heptavax B (Merck Sharpe & Dohme) approved. First vaccine licensed in the US made directly from human blood.

• Between September 29 and October 1, 1982, seven people in the Chicago area died after taking Extra-Strength Tylenol that was poisoned with cyanide.

1932—Seventy-five year ago:

• German patent filed for Prontosil, a red-dye that contained a sulfonamide group which was effective in treating bacterial infections. This introduced the first "miracle drug."

• Edward H. Land invented polarizing film leading to Polaroid-Land cameras and films in 1947.

1907—One hundred years ago:

• American Conference of Pharmaceutical Faculties (now the American Association of Colleges of Pharmacy) establish the two year curriculum as minimum for colleges of pharmacy.

By Dennis B. Worthen, Lloyd Scholar, Lloyd Library and Museum, Cincinnati, OH
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calendar

Sept. 25: ***Update on North Carolina Pharmacy:*** Wilson, NC
Sept. 7-9: ***22nd Annual Pharmacy Practice Seminar & Pharmacy-Based Immunization Delivery***, Wilmington, NC
Oct. 28-30: ***NCAP Annual Convention***, Research Triangle Park, NC
Jan 18-20, 2008: ***Southeastern Girls of Pharmacy Leadership Weekend,*** Grove Park Inn, Asheville, NC

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Convention Recap:
New Practitioner Network Holds Inaugural CE Programming

Also in this issue:

Tech ✓ Tech
Pilot Program Tests Expansion of Technician Roles

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North Carolina Pharmacist

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On the Cover

New Practitioner Network members Melinda Childress, Rachel Pendleton, Debra Wobbleton Kemp and Katherine Wurster at the *Precepting 101 & Management & Leadership Pearls* CE program at the NCAP Convention.

Inside

Please visit
www.ncpharmacists.org
to renew your NCAP membership for 2008!

Report to Owners

The end of a year is a good time to reflect on what has been done, what has not been accomplished, and what should be the focus for the future. I do that regularly because as Socrates reminded us "An unexamined life is a life not worth living." As Executive Director of NCAP I really work for you, our members. You are the owners of the Association. So let me report to you about our activities.

1. Based on 2007 projected income and expenses, membership dues represent 43% of NCAP's income. Associations like to see this figure around 25%, suggesting that non-dues income is important, and NCAP needs to work on increasing this. The positive side is that membership, and thus membership income, is growing again.

2. NCAP should finish this year with an excess of income over expenses of more than $100,000. This is quite a contrast to 2001 when I became Executive Director and we wondered if we could meet payroll at times.

3. Associations try to keep cash reserves in case of an emergency. NCAP now has assets of over $600,000, meaning we could cover one year's expenses in an emergency. Our Finance Committee is working on an investment policy to guide the Association. My initial goal when I accepted the Executive Director position was to build our reserves to $500,000. We have met that goal.

4. I am working with the NCAP Board on a transition process. My health is good, and I really enjoy my NCAP responsibilities. I am thinking I would like to stay five more years. I will then be seventy-three. Of course, you know that each day is a gift, and we don't know when we might draw our last breath, so we need to be prepared. The Board has authorized NCAP to start an Executive Residency beginning July 2008. In addition to helping provide more services, this individual will work with me to learn about NCAP. We are offering a $40,000 stipend and plan to send our Resident to three or four national pharmacy meetings. Someone interested in gaining insights on all that is occurring in pharmacy would gain much from this experience. Recommend this opportunity to any P4 student working with you now.

5. In October *Pharmacy Times* published a supplement entitled: *Asheville Today A Decade of Progress: One Community's Initiative Becomes a National Model.* In my commentary I asked "Why has the Asheville Project had such staying power? A program started locally, involving local providers with support from community leaders may well be the key." Wherever you go in pharmacy today, the Asheville Project is mentioned as pharmacy's great success story. It was NCAP pharmacy leaders who caused this to happen. As owners, take pride in what your Association leaders did to help advance our profession. The Asheville Project continues today involving more employers, more patients and more diseases. What a success story!

6. I have always had pride in the quality of North Carolina pharmacy practice. Recently I learned that North Carolina ranks third among states in the number of Mirixa MTM cases completed. If you haven't completed your cases, do it now. North Carolina ranks sixth in the number of Outcomes interventions completed. With your hard work we hope we can make ChecKmedNC the next national model of what pharmacists can do to improve patient drug therapy outcomes. NCAP will be working towards this end.

7. Your staff is a group of dedicated individuals who care about this Association. As owners, feel secure that your employees are watching out for you. When you have the chance, give a special thank you to Linda, Ron, Sally, Sandie and Teressa. They really are a tremendous resource for you.

8. NCAP and ACP started a Congressional Rotation. Two UNC PY4 student pharmacists are spending October and November in Washington serving as Congressional Fellows in the offices of David Price and Bob Etheridge. They have been well received and are really enjoying the experience. Next March and April two Campbell P4 students will do the rotation in the same offices. Through this mechanism we hope to bring pharmacy's message to our Representatives as well as prepare more pharmacists with legislative skills. We plan to expand this experience next year to more students, more offices and more states. Once again, North Carolina pharmacy is out front with a new idea that others want to emulate. We continue to build for our future.

9. Over 250 student pharmacists attended the first day of the NCAP Convention. We appreciate our three pharmacy schools' support of NCAP by encouraging student pharmacists to participate. The Pharmacy Network Foundation supports the registration scholarships for students. Once again North Carolina pharmacy shows how collaboration can make all stronger.

10. Let me close by thanking you for the privilege I have to work for you. My life has been blessed by many of you. Pharmacy has been good to me. I hope I have given back more than I gained. For me, although pharmacy has been under assault, I believe we will come out of the attacks stronger and our patients will be better served because we have changed. As someone once said to me, and I share this wish with you: May hope continue to be more than memories for you, or, said another way, may tomorrow be better than yesterday.

Thanks for your support.

Fred Eckel
Executive Director

Pharmacy Technicians: *An Essential Ingredient for the Future of Pharmacy*

The best thing about not having a crystal ball is that we can create our future with no preconceived ideas. I have, more so than ever this year, found myself planning and talking about the future of pharmacy, both within my own practice setting, as well as with pharmacy leaders throughout the state and nation. I have this picture in my head of what pharmacy will look like as early as the year 2015. When I think of the things that have to occur in order to support this vision for pharmacy practice given what we know today about future supply and demand, I always come back to one basic thing, regardless of practice setting:

> *Medication preparation and distribution processes will have to be technology-driven and technician managed.*

If you agree, then we can safely conclude that the pharmacy technician is an essential ingredient to achieving this vision for the future of pharmacy practice. Fortunately for North Carolina pharmacy, and as you will see highlighted in this issue of *The North Carolina Pharmacist*, some practices throughout the state have already begun moving in this direction to position technicians for a more advanced role. You will hear from Jerry McKee's team at Broughton where they are doing "tech-check-tech" under a waiver from the Board of Pharmacy, and you will hear about the work within the Piedmont Triad where a team of pharmacy and community college leaders are developing an Associate Degree in Pharmacy Technology program. These initiatives are just a hint of the things that must occur in order for pharmacists to more fully transition into the medication safety and patient care roles that both regulatory and professional organizations promote as the areas where pharmacists add value and improve the quality of patient care.

The American Society of Health-System Pharmacists' (ASHP) *Long-Range Vision for the Pharmacy Work Force in Hospitals and Health Systems*[1] paints a picture of the capacity of today's pharmacy departments to meet future patient care needs. It is clear that major changes are indicated in order to "support sound patient care through the safe, evidence-based and cost-beneficial use of medicines." Furthermore, it is speculated that "shortages of pharmacists are expected to be chronic [and that] technology will not eliminate these shortages." As a result, the ASHP Council on Education and Workforce Development has set forth this vision for pharmacy technicians:

> *Pharmacy technicians eventually will be defined in laws and regulations as those individuals working under a pharmacist's responsibility that (a) have completed an ASHP-accredited pharmacy technician training program, (b) are certified by the Pharmacy Technician Certification Board, and (c) are registered with state boards of pharmacy.*

Although this particular document was written specifically to provide guidance within the acute care setting, it applies to all practice settings. Not only does it begin to chart the course toward a key turning point for the pharmacy profession, it also establishes the framework for recognition that the most valued members of our teams have been requesting for years…professionalization of the pharmacy technician role. I think we can all agree…if we had a crystal ball, it would indicate that the future is bright for North Carolina pharmacy. It would also indicate that the future is now, which begs the question: What are you doing now to prepare for the future?

Beth Williams, PharmD, BCPS
President

[1] *Am J Health-Syst Pharm*. 2007; 64: 1320-30.

TECH ✓ TECH

Broughton Hospital Pharmacy technicians (front to back) Candace Wakefield, CPhT, Pamela Hughes, CPhT, and Pharmacy Technician Supervisor Kristy Martin, CPhT.

Pilot Program Tests Expansion of Technician Roles

by Jerry McKee, PharmD, MS, BCPP
Director of Pharmacy Services
Broughton Hospital
Morganton, North Carolina

Background

A Pharmacy Technician Task Force was jointly appointed by the North Carolina Association of Pharmacists (NCAP) and the North Carolina Board of Pharmacy in 2004 to determine the current utilization of pharmacy technicians in our state and to evaluate the potential for expansion of pharmacy technician roles. A final report was delivered in 2005, which included a recommendation that the North Carolina Board of Pharmacy give due consideration to the matter of utilizing pharmacy technicians to check the work of other technicians in certain tightly circumscribed practice situations. Board of Pharmacy Rule .2510 allows the Board to waive the enforcement of specific rules when:

- *Departure from the ordinary practice is designed to have a positive impact on the delivery of pharmaceutical care or designed to reduce health care expenditures;*
- *Patient health and safety are not compromised;*
- *A policy and procedure manual detailing the type and method of operation, hours of operation, and method of documentation of continuing pharmacist control accompanies the application; and*
- *The waiver is subject to continuing compliance with the conditions approved by the Board.*

Published evaluations of the performance of pharmacy technicians suggest that appropriately trained pharmacy technicians can, in fact, perform technical pharmacy services at cost savings compared to pharmacists[1]. One study suggests that the use of trained pharmacy technicians in the dispensing process allows pharmacists more time to spend on clinical activities, as well as the aforementioned cost savings. Further, a number of studies conclude that the accuracy rates of technicians who are in the role of validating the work of other technicians were superior to pharmacists in the function[2]. One study further concluded that educational training for pharmacy

technicians regarding the validation process can increase the accuracy of unit dose dispensing, which may further improve their function in this role[3]. In addition to the training aspect, the use of technology such as bar code-assisted error detection may also enhance the accuracy of either technicians or pharmacists in this quality control function.

The practice of pharmacy technicians validating the work of other pharmacy technicians is relatively new. A study in 2003 of pharmacy technician duties in hospital or institutional settings in the United States found that only eight states allowed technicians to validate the work of other technicians[4]. The issue of technician principal work validation has been debated since the early 1990's, with no clear resolution. The fundamental principle of this concept is that specialty-trained pharmacy technicians are authorized to validate the work of other technicians in filling unit dose medication cassettes as well as the refilling of automated dispensing devices in inpatient settings. Between 1998 and 2002, two pilot programs to evaluate the efficacy of this principle operated at Cedars-Sinai Medical Center and Long Beach Memorial Medical Center. The pilot programs found that technician accuracy in validating the work of other technicians exceeded accuracy rates for pharmacists[5]. From this study it was extrapolated that utilization of technicians in this manner could free California hospital pharmacists one hour each per day. Pharmacists in the pilot sites used this time to provide direct patient care services and physician drug consultations.

Given this background, Broughton Hospital, a regional state psychiatric hospital serving the western-most 38 counties of the state, located in Morganton, North Carolina, requested a waiver of Board of Pharmacy Rule .2510 to allow certified pharmacy technicians to validate the work of other pharmacy technicians where non-judgmental pharmacy functions are performed. Broughton has a mix of Pyxis technology and traditional unit dose medication cart fills comprising the medication distribution aspect of the pharmacy operation. The pharmacy staff consists of ten FTE pharmacists, eight FTE pharmacy technicians, two pharmacy assistants, and an office manager serving an average of 316 patients daily. The drug distribution aspect of the operation is highly centralized, with no more than two pharmacists staffing the central pharmacy at one time, allowing other pharmacists to practice in clinical roles. It is clear that at baseline, the pharmacy administrative day-to-day practice expectations for pharmacy technicians were high and these expectations were being consistently met or exceeded. This waiver was requested as part of a pilot program to evaluate the impact on pharmacy personnel work efficiency and effectiveness. The facility proposed to use an adaptation of a model developed and approved by the Minnesota Society of Health Systems pharmacists which was approved by the Minnesota State Board of Pharmacy in July, 2003[6]. Broughton Hospital proposed a variation of this model adapted to fit the specific needs of a regional inpatient state psychiatric hospital.

Broughton's goals for the pilot program are to utilize well-trained, competency assessed, certified pharmacy technicians (technician principals) to perform daily non-judgmental pharmacy functions, which in turn will allow clinical pharmacists to perform more patient oriented responsibilities, therefore more effectively utilizing limited professional resources. In plain terms, the hope was to free up enough pharmacist time to do morning rounds in one or more additional areas of the hospital by using pharmacy technicians as described above. Objectives also include development of an enhanced career ladder with appropriate compensation for pharmacy technicians at Broughton Hospital as we further professionalize their role in organized healthcare settings.

As an integral aspect of the Broughton proposal to the Board of Pharmacy, all technician principal work validation functions are performed in a manner such that one additional check is provided by a licensed nurse prior to administration of the medication. In the Broughton-specific care situation, all medications are administered by a nurse or licensed practical nurse after delivery by the pharmacy, and a pharmacist continues to check the preparation of all IV admixtures prepared in the pharmacy.

Data are being collected regarding technician performance, clinical pharmacist time shifted from drug distribution to clinical activities, and the nature of the clinical pharmacy activities made possible by this shift in responsibilities. This data will be shared with the Board of Pharmacy as they evaluate the pilot project and determine the future direction of other such efforts. Given the limited fiscal resources in the public mental health sector of pharmacy practice, it is imperative that maximal efficiency be derived from all staff, further underscoring the importance of this project.

In a separate but related matter of considerable concern, a nearby nine month certificate level community college pharmacy technician training program has recently been discontinued, leaving the area without a well developed didactic training program to generate new, highly trained and motivated pharmacy technician personnel. The Northwest AHEC pharmacy directors, led by Tad Adams, PharmD, are jointly pursuing discussions with another community college regarding the need for such a program for future talent development. On-the-job training of pharmacy technicians leaves much to be desired in terms of the time, energy, and resources commitment required by trainers. In our experience at Broughton, it takes months to years to obtain certain competencies via on-the-job training. By comparison, graduates of the certificate program have been found to be highly motivated, competent in a variety of areas at the point of hire, have already made a commitment to pharmacy as a professional career, and are in a position to make a more immediate impact in the workplace than comparable cohorts of on-the-job trained pharmacy technicians.

Barriers to Implementation- Unexpected Issues Discovered on the Way to Getting There

The tech check tech proposal was discussed with, and supported by, the Broughton Hospital Clinical Director, George Krebs, MD, and the hospital Chief Executive Officer, Seth P. Hunt, Jr., pending initial submission and review by the Board of Pharmacy. The proposal was reviewed and a letter of support was obtained from Eric Locklear of the Executive Committee of the North Carolina Association of Pharmacists Acute Care Practice Forum. Additionally, a variation of this concept was approved in California at the same time the Broughton proposal was submitted to the Board of Pharmacy. It further established, in a very timely manner, that the tech check tech

concept was an issue of considerable national interest and significance[7]. At the local level, as the above list demonstrates, every imaginable stakeholder was consulted and approval solicited in advance of the Board of Pharmacy hearing. No up front funding was allowed by Broughton to compensate the pharmacy technicians volunteering for the pilot, which proved to be a sticking point with technicians affected.

Broughton pharmacy technicians voiced legitimate concerns regarding significant work process changes, increased liability and responsibility, and heightened workplace stress without increased compensation. Local and state level human resources personnel were consulted and supportive of considering an additional pharmacy technician job description with increased compensation as the pilot progresses, as this is clearly an important step in the role development of pharmacy technicians. Technicians agreed to support the project, due to the clear importance locally, as well as the long-term potential for enhanced professional growth and future compensation. Essentially they agreed to take a leap of faith in following their department down this pathway with the assurance that in time, the compensation issue would be acceptably resolved.

As the proposal was being developed and discussed with pharmacy administrative peers in other settings, there were clearly mixed emotions regarding further professionalizing the role of pharmacy technicians. In some circles, the progressive utilization of pharmacy technicians is a highly polarizing issue. One common concern voiced is that of pharmacist job security if technicians are doing a significant amount of the drug product checking. However, an unexpected finding at Broughton (in an otherwise progressive department) was overcoming the inertia of the "but we have always done it this way!" school of thought. Among clinical pharmacists and pharmacy technicians, even veteran pharmacy management team members, it was often difficult to turn loose of the ideology of pharmacists as masters of the product-oriented domain in the central pharmacy. As a result, the work process changes necessitated by tech check tech have been implemented more methodically than anticipated at the program outset.

After an initial hearing of the Broughton proposal in October 2006, a site visit was conducted in December by Board members Stan Haywood, Joey McLaughlin, and Wallace Nelson, Board Inspectors Amy Cook and Karen Matthew, and Executive Director, Jay Campbell. Following the visit, the Board acted to approve a waiver of Pharmacy Rule .2510 and the pilot approval was granted for a period of two years, effective March, 2007. This aspect, as it turned out, was the simplest and most straightforward part of the entire process!

Operational Aspects of the Project

Eligibility

In order for a pharmacy technician to participate in the technician principal work validation program as a principal, a technician must be either (1) a paid or volunteer Doctor of Pharmacy intern in an approved school of pharmacy with at least six months experience in unit dose filling or (2) a certi-

fied pharmacy technician with one year's equivalent experience in unit dose filling (technicians who have not achieved certification status will not be eligible for the technician principal validation function).

Training

Didactic training with a self-learning packet developed by the Broughton Hospital Pharmacy Management Team must be successfully completed. An initial competency assessment prior to authorization to perform each task is required, along with ongoing quality assurance audits performed monthly via internal review of pharmacy medication variance reports.

Competency Assessment

For initial competency assessment, the certified pharmacy technician principal must obtain 100% accuracy rate for each separate audit. There must be, at minimum, a total of 500 line items in the cart fill validation and 100 line items in the automation refill process assessment. Competency assessment will be repeated annually as part of the department's annual competency update system. After initial competency is established, quality control and assessment shifts thereafter to a real-time, per incident review, along with monthly aggregate data evaluation as part of the facility's ongoing analysis and follow-up of each medication variance reported. Medication variance reports utilized throughout the hospital are available to follow dispensing errors which are reported by nursing.

There is a multiple-year baseline of such reports to which the technician principal data will be compared to demonstrate any emerging trends versus historical patterns. At any point in which the reported variance rate exceeds the statistical control threshold (three year historical mean plus two standard deviations), the Pharmacy Manager will review the program with the Pharmacy Management Team. Ongoing dialogue with the North Carolina Board of Pharmacy regarding program status will be provided.

Work Process Detail

The following outlines how the work process occurs with the technician principals:

A) A pharmacy technician fills the medication for the medication cart cassette refill or automated dispensing device refill.

B) An approved competency assessed, certified pharmacy technician principal validates the accuracy of the medication cart or automated dispensing device restocks. The technician principal reviews the medication for the correct drug, dose, dosage form, quantity, and reviews the expiration date of the medication packaging. Appropriate documentation of the validation process occurs.

C) If a filling error is found, the product is given back to the technician who originally filled it for correction. After correction, appropriate documentation of the validation process occurs.

D) If an approved, certified pharmacy technician principal is not available, then all unit doses must be checked in the traditional manner by a licensed pharmacist.

E) For new unit dose repackaging setups, a pharmacist must perform the initial check, and then the technician principal

may check the final product and perform subsequent checks.

Progress to Date

Effective August 10, 2007, Kristy Martin, CPhT, Pamela Hughes, CPhT, and Candice Wakefield, CPhT became designated as Pharmacy Technician Principals for the purposes of checking automated dispensing device (Pyxis) batch refills, Automed canister (automated repackaging) refills, and Euclid and Baxa fills (pharmacy repacking technology) packaging labels within Broughton Hospital's pharmacy operations. Further competency assessment and documentation is planned to allow these personnel to validate medication cart refills. Congratulations are in order for these pioneers, as well as Melinda Zimmerman, RPh, Pharmacy Operations Manager, for their outstanding efforts to reach this milestone. The process of pharmacy technician training and competency assessment was lengthy, however, it was deemed to be a situation in which *getting it right took precedence over getting it done.* As stated earlier, some of the barriers were expected while others were not. However, each had to be dealt with in a manner such that the overall project objective was not lost. After two months of early implementation, the technician principals have averaged validating 220 Automed canisters and 800 Pyxis batch refills per month. The Pyxis batch refills constitute over 10,000 doses per month. This equates to 10 hours pharmacist time per month saved at this phase of the project, with the anticipated greatest impact yet to be realized when technician principals are released to check medication cart refills.

The pilot is a local part of a national effort to further professionalize, recognize, and reward pharmacy technicians for their crucial role in the medication use process, and to provide a platform to develop a career ladder for this career track. In addition, the enhancement of the role of pharmacy technicians will allow for further deployment of clinical pharmacists in patient care activities. Pharmacy technicians have long been a crucial part of the success of pharmacy, and this pilot is another step in further enhancing their future in the profession. ❖

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Piedmont Triad Pharmacy Technician Collaborative Seeks to Establish Associate Degree in Pharmacy Technology

by Billy T. Mobley, Jr., RPh, MBA
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Forsyth Medical Center
Winston-Salem, North Carolina
Adjunct Clinical Professor
Wingate University

How can highly-trained pharmacy technicians help advance the pharmacy profession in North Carolina?

The Piedmont Triad Pharmacy Technician Collaborative was formed this year to find answers to the above question. The Collaborative is seeking to establish an associate degree in pharmacy technology and is also recommending the creation of a new practice level for technicians who receive these credentials and complete other testing, registration or licensure requirements. This endeavor is addressing several needs: 1) North Carolina ranks seventh among the top ten fastest growing states[1] which means an increasing need for healthcare providers, 2) North Carolina currently has the second highest demand for pharmacists in the nation[2], 3) while the number of pharmacists graduated in the state is increasing, supply is not meeting demand, and 4) a common belief that well-trained pharmacy technicians are part of the answer. For this collaborative to succeed there needed to be a common vision and a united front from teaching facilities and pharmacy providers. Davidson Community College, Forsyth Technical Community College and Guilford Technical Community College partnered with Forsyth Medical Center, Moses Cone Hospital, Wake Forest University Baptist Medical Center and the Northwest Area Health Education Center to begin this innovative endeavor.

To assure a common vision and a united front, the pharmacy providers first presented the current state of pharmacy practice, the needs of the pharmacy providers, and a goal of establishing the associate degree program. The focus then shifted to whether the degree program was a viable solution to help meet pharmacy's needs and the desire of the community colleges to become involved in the project. As part of the introduction to the specific needs of the pharmacy providers, some historical information was provided to the community college participants.

In 2001 the Pharmacy Manpower Project predicted a significant shortage of pharmacists based on the projected demand for pharmacy services through 2020. The conference noted that the need for filling medication orders and providing drug therapy management were "inextricably intertwined" and surmised that "unless an even more dramatic solution is adopted to meet the forecasted demand for dispensing, the expansion of direct patient drug therapy management by pharmacists will fall far short of need." While not specifically addressing the role or qualifications of pharmacy technicians, the conference stated that one of the required actions of the profession was to "fully utilize technology and technicians for order fulfillment."

The American Society of Health-System Pharmacists (ASHP) has stated that, "Pharmacists have long recognized the need for a corps of technically trained personnel in the profession of pharmacy. This need arises from the fact that the practice of pharmacy encompasses a complex set of tasks in a wide array of environments, some of which require the knowledge and judgment of a pharmacist, but many others that do not. Increased utilization of well-trained and appropriately supervised technicians is a key component of pharmacy's strategy for moving beyond its traditional functions."

In 1995, ASHP, in conjunction with the American Pharmacists Association, the Illinois Council of Health-System Pharmacists and the Michigan Pharmacists Association established the Pharmacy Technician Certification Board (PTCB) as an independent body to create and administer national voluntary certification examinations. The establishment of the PTCB provided a method to assess the basic competency of pharmacy technicians and since 1995, over 260,000 technicians have passed the exam. The collaborative felt this was a great start, but believed that, for technicians to become the asset that allows pharmacists to better transition into managing drug therapy and becoming more involved in direct patient care, additional steps were necessary.

As early as 384 BC, Aristotle dealt with a similar problem that the Collaborative faced. Aristotle's question was literally, which came first the chicken or the egg? With respect to reaching the vision of an associate degree technician with expanded responsibilities, the Collaborative needed to assess the timing of the proposal to succeed. Do we first create the degree, propose a new level of technician practice, and finally prove the ability of the graduates to perform more advanced functions; or do we prove the capabilities of a highly-trained technician workforce and then ask that a degree program and a new level of practice be created – chicken or egg? In reviewing what skills were needed in the advanced technician we sought to develop, the Collaborative felt that first creating the associate degree was essential. The technician we seek to develop needs not only pharmacy skills, but the benefit of the core courses required of an associate degree including interpersonal communication and critical thinking skills.

Fortunately for the Collaborative, there were two starting points already in place to build the curriculum for the associate degree program. First, the North Carolina Community College System provides a framework for first-year core courses. Second, two of the community college systems already had in place basic coursework designed to introduce students to pharmacy practice, train them in basic pharmacy skills, and prepare them to take the CPhT exam. The Collaborative is currently moving to formalize the first-year courses. It is also building upon the pharmacy technician courses currently in place to develop coursework that will produce a highly-skilled technician and meet the credentialing requirements for an associate degree.

In addition to a curriculum, the associate degree program will need coordinators, teachers and equipment for each community college, which the Collaborative estimated would cost close to $1 million dollars over the first five years. The Collaborative was successful in receiving a grant for curriculum development and has submitted for grants for these additional needs. To demonstrate their commitment to developing the associate degree program, the three hospitals have pledged for approximately

half of the grant requirements.

The vision for an associate degree technician has had an excellent start and received tremendous support from the leadership at all of the institutions involved, but we recognize that for success, wide-spread support must be established. Four members of the Collaborative plus representatives from Walgreens met with the Pharmacy Board on May 15th to present our vision and request the Board's support. The Collaborative was pleased with the Board's response in the minutes of the meeting where they stated:

The proposal would recognize a technician's skill and allow them to play a greater role in drug distribution performing technical duties. The proposal, of course, is not to replace the pharmacist, but to assist the pharmacist. This type of program for pharmacy technicians would help ensure that pharmacists can focus less of their time on traditional, mechanical dispensing functions, and more of their time on clinical monitoring of drug therapy regimens. Studies have shown repeatedly that such a shift in pharmacy practice focus results in improved patient care, better patient outcomes, and reduced overall health-care costs.

Widespread implementation of this pharmacy practice model simply cannot occur without a much larger pool of well-trained pharmacy technicians. Unfortunately, there has been relatively little standardization and strengthening of pharmacy technician training over the years. This state of affairs makes it difficult to increase pharmacist technician responsibilities, which in turn makes it difficult for pharmacists to focus less on the dispensing process and more on monitoring drug therapy.

The Board was in full support of this proposal. Mr. Campbell stated that there are currently 10,908 registered technicians with the Board, but only 3,775 are certified through the Pharmacy Technician Certification Board.[3] A motion was made to write a letter to support the grant being requested by the group and the motion passed without a dissenting vote.

Now the Collaborative seeks to gain your support. Currently 28 states, including the surrounding states of Georgia, South Carolina, Tennessee and Virginia have associate degree programs to prepare technicians to successfully pass licensure and certification examinations. We feel the time is now to develop an associate degree program in North Carolina. Our pharmacy schools are producing excellent clinicians who graduate with both the skills and desire to provide drug therapy management that results in excellent patient outcomes. For them to succeed and for our profession to reach new heights, the collaborative asks for your support as we seek to develop highly-skilled technicians to assist them.

In 1966, Linwood F. Tice, Dean of the Philadelphia College of Pharmacy and Science, stated "The counting and pouring now often alleged to be the pharmacist's chief occupation will in time be done by technicians and eventually by automation. The pharmacist of tomorrow will function by reason of what he knows, increasing the efficiency and safety of drug therapy and working as a specialist in his own right. It is in this direction that pharmaceutical education must evolve without delay."

The Collaborative thinks we have delayed enough and is confidant that you will be impressed and see the value of the technicians we develop. ❖

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MUTUAL MEMBER DRUG

Institute of Pharmacy Houses New Tenant

The North Carolina Association of Pharmacists is now sharing office space with Tom Murry, PharmD, JD, Executive Director of the Pharmacy Compounding Accreditation Board (PCAB).

Tom is a member of NCAP and has worked with the Association on a number of activities in the past. He approached NCAP because he believed that having his North Carolina office in proximity to NCAP would be synergistic for both organizations. NCAP's Executive Director, Fred Eckel, presented the idea to the Endowment Fund who also recognized the potential value in housing PCAB at its office in the Institute of Pharmacy building in Chapel Hill.

In 2004, PCAB was organized to create a voluntary system of nationwide standards for compounding pharmacies and was founded by eight of the nation's leading pharmacy organizations: American College of Apothecaries, American Pharmacists Association, International Academy of Compounding Pharmacists, National Association of Boards of Pharmacy, National Alliance of State Pharmacy Associations, National Home Infusion Association, National Community Pharmacists Association, and the United States Pharmacopeia. These organizations created PCAB because they felt it was an important step for the profession of pharmacy and the practice of compounding given the increased demand for compounded medications and the increased scrutiny of compounding from numerous fronts.

TM PCAB PHARMACY COMPOUNDING ACCREDITATION BOARD

PCAB Mission

The mission of PCAB is to serve the public good by serving patients, prescribers, and the pharmacy profession. The PCAB mission is:

- to organize and carry out a comprehensive program of voluntary accreditation in the practice of pharmacy compounding.
- to promote, develop and maintain principles, policies and standards for the practice of pharmacy compounding in the public interest and to apply these in the accreditation of pharmacies that offer pharmacy compounding to improve the quality and safety of pharmacy compounding provided to the general public.
- to offer to the public and prescribers a way to identify the pharmacies that satisfy accreditation criteria.
- to provide a public forum for information on the practice of pharmacy compounding, and to educate the public on the importance of pharmacy compounding.

The PCAB Principles of Compounding and PCAB Standards are the two main tools by which PCAB carries out its mission.

PCAB Principles of Compounding

Every pharmacy that applies for PCAB Accreditation must agree to abide by the PCAB Principles of Compounding. These principles state that compounding is the preparation of components into a drug product either as the result of a practitioner's prescription drug order based on a valid practitioner/patient/pharmacist relationship in the course of professional practice, or for the purpose of, or as an incident to, research, teaching, or chemical analysis that are not for sale or dispensing. Additionally, the principles state that compounding is a part of the practice of pharmacy subject to regulation and oversight from the state boards of pharmacy and that compounded medication may be dispensed to prescribers for office use, where applicable state law permits. Office use does not include prescribers reselling compounded medications.

The principles allow for compounding conducted in anticipation of receiving prescription orders when based on routine, regularly observed prescribing patterns. This anticipatory compounding is limited to reasonable quantities, based on such patterns. The principles also state that compounding does not include the preparation of copies of commercially available drug products. Compounded preparations that produce, for the patient, a significant difference between the compounded drug and the comparable commercially available drug product or are determined, by the prescriber, as necessary for the medical best interest of the patient are not copies of commercially available products. "Significant" differences may include, for example, the removal of a dye for a medical reason (such as an allergic reaction), changes in strength, and changes in dosage form or delivery mechanism. Price differences are not a "significant" difference to justify compounding.

The principles state that both the prescriber (via the prescription) and the patient (via the label) should be aware that a compounded preparation is dispensed. The principles state the pharmacy may advertise or otherwise promote that it provides prescription drug compounding services. Such advertising should include only those claims, assertions, or inference of professional superiority in the compounding of drug products that can be independently and scientifically substantiated.

PCAB Standards

The PCAB standards are rigorous. PCAB uses two methods to determine whether a pharmacy is in compliance with the PCAB standards: (1) extensive review of written policies and procedures and (2) an on-site survey of the pharmacy. It is crucial to note that the pharmacy's written policies and procedures must reflect the actual practice of the pharmacy. A pharmacy which has a policy and procedure manual that meets PCAB standards, but the actual practice of the pharmacy fails to meet PCAB standards will not be awarded PCAB accreditation.

The PCAB standards cover several core areas of both sterile and non-sterile compounding, including training of personnel, storage of chemicals, proper equipment usage, beyond-use-dating, packaging, labeling, patient education, and quality assurance. It is important to note that PCAB requires compliance with both USP <795> and USP <797>.

PCAB Accredited Compounding Pharmacies

Many NCAP members often have patients who need a prescription compounded. When choosing a compounding pharmacy

to whom you refer your patients, PCAB suggests looking for the designation "PCAB Accredited™ compounding pharmacy" or the PCAB Seal. For a list of PCAB Accredited compounding pharmacies in your area, visit http://www.pcab.org/find-a-pharmacy.shtml. Currently, there are two PCAB accredited pharmacies in North Carolina and thirty-two nationwide.

About Tom Murry

Tom earned his pharmacy degree at the University of Arkansas. Following graduation, he served as the National Community Pharmacy Association's first Executive Resident, and subsequently served as NCPA Director of Student Affairs. In May, 2007 Tom graduated from the Campbell University School of Law. Tom is licensed to practice law in North Carolina, and pharmacy in Arkansas, North Carolina, and Virginia. Tom, and his wife Tamara, who is also a pharmacist, have two daughters: Ella, almost 4 years old and Gretchen 13 months. Tom lives in Morrisville where he serves on the Town Board. ❖

Calendar

Jan 18-20: Southeastern Girls of Pharmacy Leadership Weekend, Asheville
Feb. 3-5: Acute Care Practice Forum Meeting, Concord, NC
April 12: OTC Drug Advisor Certificate Program, Chapel Hill
April 12: Immunization Certificate Program, Chapel Hill
April 13: Community Care Practice Forum Meeting, Chapel Hill
April 16-18: Chronic Care Practice Forum Meeting, Concord
July 11: Residency Conference, location to be announced
Sept. 20: Student Leadership Conference, Pinehurst
Oct. 26-28: NCAP Annual Convention, RTP

2008 Update On NC Pharmacy:

April 24	Asheville
April 29	Raleigh
May 1	Fayetteville
May 5	Greenville
May 6	Winston-Salem
May 8	Charlotte
May 12	Wilson
May 15	Greensboro
May 29	Wilmington

For more information visit www.ncpharmacists.org

NCAP Offers Online Pharmacist Refresher Course

NCAP has partnered with the Connecticut Pharmacy Association to offer The Pharmacist Refresher Course, an online course designed for pharmacists who wish to return to community pharmacy practice after an absence from practice for three or more years. The course consists of three modules, all of which have been approved for ACPE credits. The first two modules are completely online and composed of weekly study segments that allow course participants to work at their own pace, on their own time. The third module consists of a three-week, 90-hour live experience in a community pharmacy. Only those who participate in all three modules will earn a Pharmacist Refresher Course Certificate from Charter Oak State College. Those taking modules One and/or Two for personal enrichment will earn ACPE credits through CPA.

and...

A Two-Week Online Pharmacy Law/QA Course

This course will give home study law credit to any pharmacist wanting to learn about quality assurance strategies and North Carolina's pharmacy laws. This course can be used to prepare for reciprocity into North Carolina, or for those who want an update on Pharmacy Law and Quality Assurance. Students must follow a two-week course schedule. Online discussion boards and instructor monitoring and interaction keep you on track throughout the course. The course is offered the first two full weeks of every month. The registration deadline is the Thursday before each monthly course starts. This course is accredited by ACPE for 15 hours of home study law education.

For More Information visit our Web site at www.ncpharmacists.org or Call NCAP at 919-967-2237.

Today's pharmacists are being called on to play a greater role in the development of future pharmacists. This CE learning activity is designed to help prepare and support preceptors to conduct successful experiential rotations.

The Community Pharmacist Preceptor Education Program

Visit www.nacdsfoundation.org or www.pharmacist.com/education to access this FREE program.

Learning Objectives

After completion of this program, pharmacists will be better able to:

- Develop the skills needed to be an effective preceptor.
- Explain the benefits of precepting for preceptors, student pharmacists, community pharmacies, and the profession of pharmacy.
- Describe the components of introductory and advanced experiential education.
- Prepare student pharmacists to enter practice and/or the next level of pharmacy training.

For a complete list of learning objectives, please contact the provider.

The National Association of Chain Drug Stores (NACDS) Foundation and the American Pharmacists Association (APhA) are accredited by the Accreditation Council for Pharmacy Education (ACPE) as providers of continuing pharmacy education. This home-study activity has been assigned a maximum of 3.00 contact hours (0.3 CEUs) and the Universal Program Number is 206-202-07-008-H04.

To receive continuing education credit for this course, participants must complete an online evaluation form and pass the online assessment with a score of 70% or better. If you do not receive a minimum score of 70% or better on the assessment, you are permitted one retake. After passing the assessment, you can print and track your continuing education statements of credit online. There is no fee to participate in this activity.

Supported by an educational grant from MERCK

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NACDS FOUNDATION

Record Breaking Attendance Set at 2007 NCAP Convention

Over 1,000 pharmacy professionals were on hand for the 2007 NCAP Convention held October 28-30 at the Sheraton Imperial Hotel in RTP, NC. On Monday morning, President Beth Williams' opening remarks were followed by the Rite of Roses ceremony honoring members who have died since the previous Convention. Julian Emmett Upchurch, Jr. of Durham and John Mitchell Johnson of Raleigh were inducted into the 50 Plus Club to honor their 50 years of service as licensed pharmacists. Many other awards were presented throughout the day (seen next page). More than 70 exhibitors filled the ballroom along with the Residency Showcase on Monday afternoon. That evening, North Carolina's three pharmacy schools hosted receptions.

The Convention concluded on Tuesday afternoon with a presentation from nationally acclaimed speaker Wayne Sotile, PhD.

Student scholarships to cover the cost of registration were made possible by a grant from the Pharmacy Network Foundation.

Congratulations to Abbie Williamson who won a free one-year NCAP membership for sponsoring a new member in the "Reach One for NCAP" membership campaign. A special thanks goes to all of those who successfully promoted NCAP to their peers and recruited new members in 2007:

Jim Beardsley
Kayren Brantley
Ken Burleson
Jay Campbell (2)
Dawn Cender
Melissa Durkee
Fred Eckel (3)
Stefanie Ferreri
Jennifer Gommer
Troy Hilsenroth
Christopher Brian Holloman
Carol Mayben
Elizabeth McGowan
Michael Nnadi
Steve Novak
Brenden O'Hara (2)
Mollie Scott
Penny Shelton (2)
James Stefanadis (2)
Christopher Tart
Carl Taylor
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Sepracor
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VIP Computer Systems, Inc.
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Wyeth

2007 NCAP Annual Convention

Members Honored for Outstanding Service

On behalf of Wyeth Pharmaceuticals, Fred Eckel presents the distinguished Bowl of Hygeia Award to Betty Dennis.

In appreciation of her service as the 2007 President of the Association, Fred Eckel presents the NCAP President's Award to Beth Williams.

Fred Eckel presents the Don Blanton Award to Dean Robert Supernaw for his contributions to the advancement of pharmacy in North Carolina.

Beth Williams presents the President's Service Award to Brendon O'Hara in recognition of his outstanding contributions to NCAP.

Dan Ward of McKesson presents the McKesson Leadership Award to incoming NCAP President Penny Shelton. Penny also received the National Community Pharmacists Assoc. Leadership Award.

On behalf of Pharmacists Mutual Companies, Fred Eckel presents the Distinguished Young Pharmacist Award to Stefanie Ferreri.

Mary Beth Rice and Marc Cochran of Hire Dynamics Rx.

On behalf of Elan, Fred Eckel presented the Elan Biopharmaceuticals Innovative Pharmacy Practice Award to Ron DeVizia for pharmacy practice resulting in improved patient care.

Penny Shelton presents the Campbell University School of Pharmacy Preceptor of the Year Award to Angela Elliott.

Kim Leadon presents the University of North Carolina School of Pharmacy Preceptor of the Year Award to Davie Waggett.

Lisa Smith presents the Wingate University School of Pharmacy Preceptor of the Year Award to Scott Romesburg.

Fred Eckel (right), representing Pharmacy Times, and Wal-Mart representative Greg Gurley (left), present the RESPy Award to UNC Pharmacy Student Lisa Adams. RESPy stands for Respect, Excellence, and Service in Pharmacy.

There is always something very interesting going on in the exhibit hall.

Exhibitor Sam Mordecai of Alsco Cleanroom Services pals around with his "floor model."

Silver Sponsor AstraZeneca's representative chats with convention attendees.

Save the Dates for NCAP's 2008 Meetings:

Acute Care Practice Forum, Feb. 3-5 • Community Care Practice Forum, April 13
Chronic Care Practice Forum, April 16-18 • NCAP Annual Convention, Oct. 26-28

Waggett Honored by NCPA For Work With Pharmacy Students

John Davie Waggett, RPh, was named the 2007 National Preceptor of the Year by the National Community Pharmacists Association (NCPA) during its 109th Annual Convention and Trade Exposition held October 13-17 in Anaheim, CA. The National Preceptor of the Year Award honors a pharmacist who has made significant contributions to the education of pharmacy students by devoting time, talent, and effort as a preceptor.

"For nearly 30 years, Davie has served his community and the pharmacy profession well. Davie is an example of how a dedicated community pharmacist can serve as an example to future pharmacists not only at his alma mater, but also nationwide," said Bruce Roberts, RPh, executive vice president and CEO of NCPA.

A pharmacist for 29 years, Davie is the owner of Seashore Discount Drug and Winter Park Discount Drug in Wilmington, North Carolina. A graduate of the University of North Carolina at Chapel Hill School of Pharmacy, he has since served as a preceptor to more than 20 UNC School of Pharmacy students and was recently awarded the 2007 UNC Community Preceptor of the Year Award for his work.

In addition to being a member of NCPA, Davie is a member of the American Pharmaceutical Association. He is also a member and past president of the North Carolina Association of Pharmacists and the Association of Community Pharmacists and has served as chairman on various boards and committees of those organizations. He is a former president of the Tri-County Pharmacy and the New Hanover Pharmacy Associations and serves on the board of directors for North Carolina Mutual Wholesale Drug.

In his community, Davie is a member of Pine Valley United Methodist Church, serving as a youth counselor, member of the church council and chairman of the Health Ministries Team. He is president and past vice-president of the Henderson Jaycees, is on the board of directors for the Bank of Wilmington and on the board of the Supper Optimist Club for which he has also served as a former Vice President and President. He also serves as chairman of the board for Medsource, Inc., a county-wide organization that solicits grants and funds to provide medications for people who cannot afford their medications but are ineligible for programs such as Medicaid.

As the winner of the National Preceptor of the Year Award, a $1,000 donation will be made in his name to the pharmacy school of his choice.

Campbell Pharmacy School Welcomes Rite Aid Back to NC

With the June 4 acquisition of Brooks Eckerd, the Rite Aid Corporation has again established a presence in North Carolina. The company, which is the largest drug store chain on the East Coast and the third largest in the nation, boasts 5,100 stores in 31 states and 115,000 associates. The integration of nearly 250 acquired stores in North Carolina is expected to be completed within the next 16 months.

To Campbell University's School of Pharmacy, which hosted a welcome back luncheon for several Rite Aid corporate administrators recently, the corporation's return to the neighborhood means much more than just superior goods and services.

"This is strictly a win-win situation," said pharmacist Jimmy Jackson, adjunct professor of pharmacy at Campbell and a consultant and lobbyist for Spoke Consulting, Inc. "It's great for Campbell to have this business return to North Carolina. Rite Aid will employ a lot of those people who are actively pursuing a career in pharmacy and, through rotations and internships, provide new opportunities for students."

Ronald Maddox, dean of the Campbell School of Pharmacy, and Penny Shelton, director of Experiential Programs and president-elect of the North Carolina Association of Pharmacists, agreed.

"Not only do we have the opportunity to train our students and employ our graduates through Rite Aid's support, but our graduates will find job opportunities available to them throughout the East Coast," said Maddox.

The return of Rite Aid also offers another important opportunity, Shelton added. "It's nice to have corporate support and to see a company that will model professionalism for our students to mirror," she said. "They are laying down a great foundation for professional involvement that, hopefully, will translate into employees, pharmacists and our students becoming more and more active in our professional associations."

Bob Cisneros spreading animal balloon cheer.

Cisneros Named National Advisor Of The Year For Pharmacy Fraternity

Bob Cisneros, assistant professor at Campbell University's School of Pharmacy, was selected as the Chapter Faculty Advisor of the Year for Phi Delta Chi. The mission of Phi Delta Chi Pharmacy Fraternity is to develop leaders to advance the profession of pharmacy and promote scholastic, professional and social growth in the students.

"When I found out I was selected I was completely surprised," said Cisneros. "I was told by the students I had been nominated, but I really didn't expect to receive this honor."

Chapter member Joanna Hammond said, "We nominated Dr. Cisneros because he is an excellent role model and advisor, he has pride in Phi Delta Chi, he has leadership ability, empathy for others and has strong Christian values."

Cisneros enjoys being a part of the pharmacy fraternity because it is a great way to connect with the students and help with their professional development.

"The students develop leadership skills and learn to work with people," he said. "Phi Delta Chi helps prepare students for the real world."

Phi Delta Chi is involved in training and educational programs to improve the therapeutic, leadership and management skills of its members, provide service programs to help the community and host social activities for the members.

CU Pharmacy Teaching Facility Dedicated to Dean Maddox

Like a proud parent, Ronald Maddox, dean of the Campbell University School of Pharmacy, looked on as the school's new 42,000 square-foot pharmacy teaching facility, Maddox Hall, was dedicated in his honor on Wednesday, Oct. 3.

As its founding dean, Maddox played

an integral role in the growth of the School of Pharmacy, from its establishment in 1986 with only 54 students to its current enrollment of 435 students in the School of Pharmacy and over 1,000 students in pharmacy related programs at Campbell. He has overseen the development of the pharmacy school's comprehensive degree program—including bachelors and masters degrees in Pharmaceutical Sciences and Clinical Research and the Doctor of Pharmacy degree. And he has witnessed the school's phenomenal performance on both state and national exams—an overall 99 percent passage rate on all state board exams and a 98 percent passage rate on the national exam.

Located between the Science Building and Carter Gymnasium, Maddox Hall features classrooms, a student study center, breakout rooms, administrative and alumni suites, two 3,534 square-foot lecture halls, faculty offices, a Professional Association Room, and close to 6,000 square-feet of laboratory space and lab preparation area.

Faculty Members Participate in 2007 Nonprescription Medicines Academy Conference

Beth P. Spencer of Wingate University and Jennifer D. Smith of Campbell University were among forty-six college of pharmacy faculty members, representing schools and colleges of pharmacy from across the country, who recently participated in the 2007 Nonprescription Medicines Academy (NMA) held Oct. 4-6 in Cincinnati, Ohio. This was the 10th annual meeting of the Academy, which began in 1998 as an educational conference planned exclusively for faculty who provide instruction on nonprescription medicines and medical devices. The goal of the Conference is to support a learning environment and networking opportunity for faculty to interact and share ideas, stimulate new teaching methodologies, and promote research concepts in the nonprescription arena.

The Conference programming includes presentations on topics including education, research, and current public health issues in the area of nonprescription medicines. As a condition of selection, each faculty member is expected to share an instructional innovation from their coursework or a project or research initiative as a brief oral presentation or poster during the Conference.

Campbell Students Take Part In Medical Missions Trip To Africa

When students are asked the question "How did you spend your summer break?" most will talk about going on vacation or catching up on sleep. But three Campbell University students spent three weeks of their summer break working on a medical missions trip in the wilds of Africa.

Jennifer Cavenaugh, Sarah Erbaugh and Nashea Turner, all fourth-year pharmacy students, worked at a free clinic in conjunction with Beacon of Hope and at Gertrude's Children's Hospital.

"While we were there, we worked in clinics handing out prescription medications," said Erbaugh. "The first clinic was in a Masai village near the border of Tanzania. The second was in a slum in Nairobi."

Turner described the clinic at the Masai Village as a life changing experience.

"The Masai tribe lived on a big open desert land with mud and stick huts for houses. The dirt and dust flew around all the time so the people had bad allergies and eye problems," said Turner. "There were only three of us running the clinic. The Masai people would line up and then be examined by one of the three of us. We would determine what was wrong with them and dispense medication to them."

They stayed busy for the entire time, but managed to get in a day of sightseeing.

"We were able to go on a safari and see a giraffe park," said Erbaugh. "Kenya is beautiful with so much to offer. It would be a shame to go there and not see the country." ❖